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ABSTRACT

This theme issue offers a collection of articles focusing on support groups for parents of infants and toddlers, including the following: (1) "Gaining Perspective on Parenting Groups" (Nick Carter and Cathie Harvey) which reviews the purposes, history, and essential ingredients of such groups; (2) "The MELD Experience with Parent Groups" (Joyce Hoelting and others) which describes the Minnesota Early Learning Design group-based parenting education program; (3) "Revisiting Parenting Groups: A Psychosocial Approach" (Barbara Frazier and others) which describes implementation of a new parent education model in Florida's Child Abuse Prevention Project; (4) "Family Support While You Wait: Lessons from the Detroit Family Project" (Susan Whitelaw Downs and Donna Walker) which describes a program providing casual parent education services in clinic waiting rooms; (5) "Getting a Shot at Life through Group Action Planning" (Ann P. Turnbull and others) which describes a family support model including characteristics of both individualized team planning and support groups; and (6) "Beyond the Pizza Dinner: Natural Alternatives to Parent Support Groups" (Tracy Price-Johnson and Lucy Miller) which describes an effort to create opportunities for informal relationships among parents of typically developing children and children with disabilities. Also included are a list of 45 Zero to Three articles on parenting groups and descriptions of seven recent books and two videotapes. (Individual articles contain references.) (CR)

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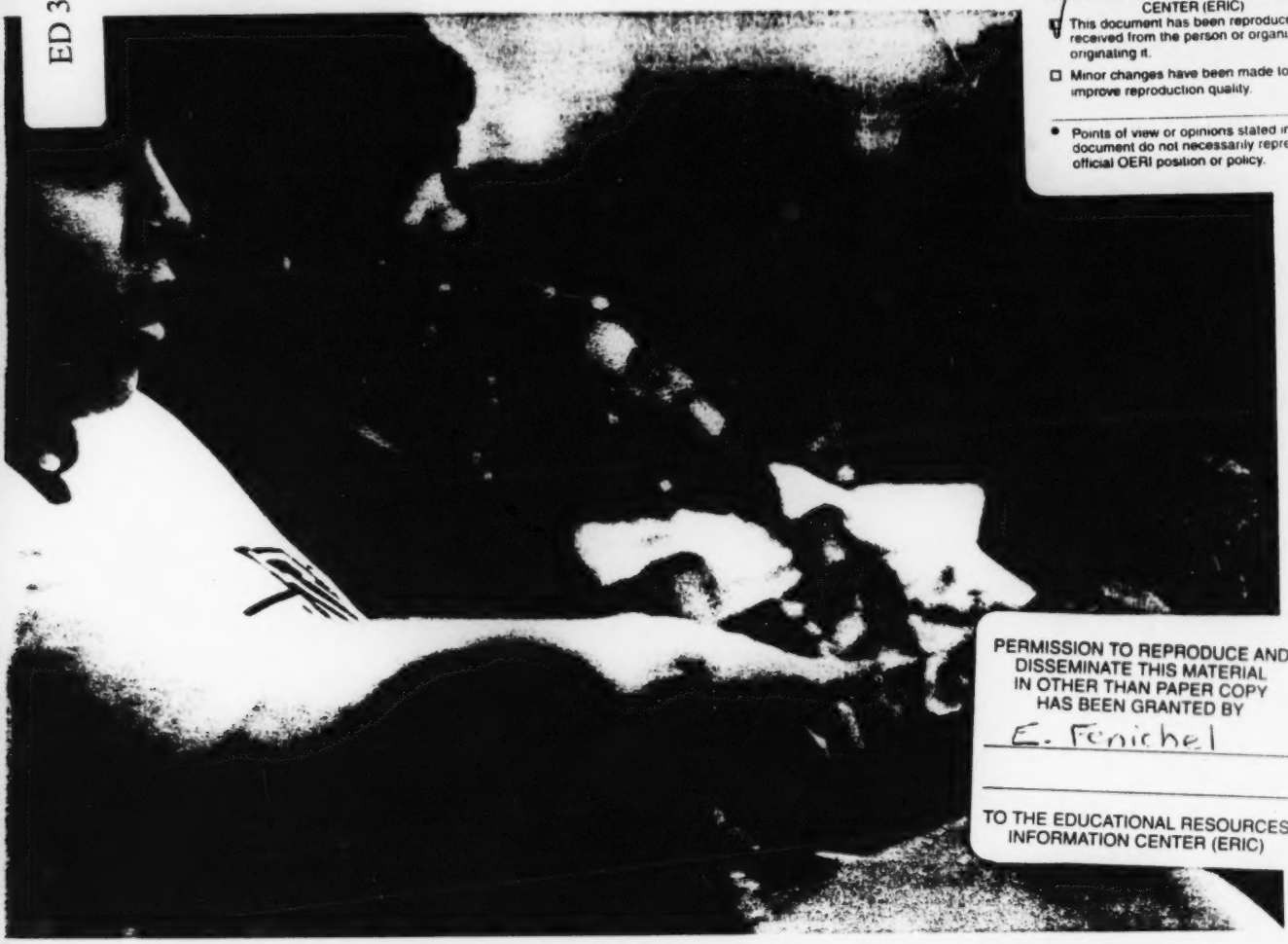

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MELD

Gaining Perspective on Parenting Groups

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A few snapshots:

• An attentive gathering of parents in an early intervention program listens as a father describes how his life has changed since the birth of his son with spina bifida.

• A mother in a transitional housing program decorates a tee shirt with her family tree and talks with other mothers about her family traditions.

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Editor's Note

This issue of Zero to Three, an exploration of parenting groups from a range of perspectives, is the result of many conversations—the kind of collaborative dialogue that enriches our field. About 15 months ago Nick Carter visited our office, telling us some of the things he was learning in a nationwide study of the phenomenon of parenting education and support. This was a week or so after Annie McPherson had telephoned; she was interested in letting others know about the fresh look she and her colleagues in Florida had taken at parenting groups as a way of supporting parents in rural areas with multiple challenges. We wondered how many other people were re-examining parenting groups.

Many conversations later, an issue of Zero to Three has been created— in a process not unlike the one Nick Carter and Cathie Harvey describe as typical of effective parenting groups. The contributors to this issue—parents and practitioners alike—validate each other's experience, admit uncertainty, do not demand uniformity, exchange a variety of perspectives, and consider many possible effective responses to the challenges of their own circumstances. We hope that their generosity with the wisdom they have gained will help others —in groups or out—feel nurtured, reinforced, and encouraged to reflect on the process of parenting very young children.

Emily Fenichel, Editor

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Gaining Perspective on Parenting Groups

continued from page 1

• Amid soft laughter– and a few sighs of exasperation—parents and staff of a child care center offer examples of tough questions that preschoolers ask about sexuality, searching together for helpful responses.

• A couple in their sixties who have become primary caregivers of their daughter's three-year-old daughter and infant son eagerly participate in a simulation exercise about setting limits.

When parents gather in groups, there is always the possibility of magic. There are wonderful moments when a parent realizes — with relief — "I'm normal!" or —perhaps even more important—"I'm not alone!" Then too there is that spontaneous moment of caring when a few parents in the group offer emotional support and practical help for the mother who is sleep-deprived and feeling overwhlemed with being a new parent. Frequently, a catharsis occurs: a group of parents emerges from a time of struggle and begins to celebrate the discovery of their collective identity and the strength of the bonds they have forged together. At these times, the facilitators of the group know (and can report to their sponsors) that what they do works. Discussions of theories, goals, and definitions of parenting groups seem remote and somewhat beside the point.

Sometimes, however, attendance is erratic. Parents are not engaged, or, alternatively, intense interactions between group participants demand far more of the leadership than anyone bargained for. Enthusiasm wanes; "magic moments" are history. An observer might legitimately wonder whether participants, facilitators, or sponsors are using parent groups effectively — or even understand what they are trying to do.

Based on a recent national review of parenting programs there are today more than 100,000 groups of parents that meet during any given year (Carter, 1995). This number includes time-limited parenting education groups that meet for 8 or 12 or 16 sessions; open-ended weekly or bi-weekly parent-child groups; groups of participants in an ongoing child care or early intervention program who meet monthly or quarterly; participants in therapeutic or self-help groups focused on family or parenting issues; and parents who assemble for a single workshop or discussion.

In this diverse proliferation, parenting groups have established themselves as a staple of parenting education and family support programming. They have the ability to nurture participants in their parental roles by addressing many child-rearing needs that few other methods can do as effectively. Parenting groups can enable participants to overcome isolation, develop peer support systems, and create learning communities.

A close examination of these groups reveals that the critical dynamic for their success is far more the **process** of what is happening among the participants than the content of what they are discussing. With skilled leadership, group process—the interactions among participants that provide the context for participants' growth, development and change—can create extraordinary possibilities. The universal parental search for normalcy and support—something most readily available from other parents—can often find its fullest expression through this process.

We view the parenting group, then, as both a method of practice and a strategy for delivering parenting education and family support. This definition implies the use of group process as a means to promote an individual's growth and development as a parent: the group becomes the context for change. This view of the parenting group acknowledges and invests in peer interaction as a basis for individual education, support and change. Thus a "parenting group" is not the same as a group of parents whose primary purpose is collective action—for example, parent advisory groups, parent involvement initiatives, or parent advocacy groups. Finally, this definition distinguishes the parenting group from other strategies for growth and change that rely primarily on a one-to-one relationship—for example, home visiting, case management, or individual counseling.

Too often the parenting group has been adopted as a methodology and a strategy without adequate assessment of its appropriateness, given the needs of the people it is intended to serve and the objectives it is designed to achieve. With equal frequency, parenting groups lack key supports for success—for example, properly trained and supervised facilitators, or guarantees of confidentiality for participants. In this essay, we will review and analyze many of the factors that determine why one parenting group is successful and another is not. The issues we will raise and the challenges we will offer will be addressed in greater detail by our fellow contributors to this issue of *Zero to Three.*

Goals of parenting groups

Overcoming isolation

One of the most frequent comments made by parents in evaluation of their experience in a parenting group is: "I learned that I'm not alone." This statement reveals a great deal about the appeal of the group as a method of parent support and education—as well as about all parents' need for perspective and support. Parents are constantly asking, aloud or by implication, "Am I normal?" At some level, every parenting group responds to this question. For example, as one parent begins to voice pent-up feelings of frustration and anger engendered by

the ceaseless demands of an active toddler, a sense of relief sweeps the group. Difficult emotions are not indicators of individual failure; they reflect an all-too-common experience.

The group setting gives parents "permission" to admit to uncertainty and guilt, to be vulnerable, and to ask "dumb" questions. Parents validate each other's experience and genuinely appreciate the emotional energy required by the mundane, yet critical details of caring for a young child. Parenting groups do not demand uniformity as the price of belonging. Rather, they offer parents an opportunity to exchange a variety of perspectives and consider many possible effective responses to a given parenting issue. Parents need not feel pressured to adopt any single "right way." Instead, they are encouraged to reflect on their own beliefs and behaviors. In the group, they can listen to a range of ideas and use them as a basis for fashioning a response that will be appropriate for their unique circumstances.

Developing peer support systems

In parenting groups, participants are encouraged to provide nurturance, empathy, opportunities for reflection and positive reinforcement for each other. They often take turns providing refreshments for the meetings. They may give each other permission to be "good enough" (instead of "perfect") or to let go of assumptions and expectations that they realize may be harmful to children's healthy development. They may use the platform of mutual respect and their newly formed bonds to raise questions and make observations about each other's experiences.

Groups are fertile ground for peer support of personal growth and development. They can foster a sense of shared purpose among parents and help to illuminate significant aspects of parents' personal histories and circumstance. Parents can appreciate (and celebrate!) the meaning of another parent's insight, accomplishment or shift in attitude—no matter how small the change might

The historical roots of parenting groups

The use of groups for education and social support is not a new idea. Mutual self-help groups — the antecedent of parenting groups — trace their beginnings to the 1930's and the Alcoholics Anonymous model of support for people in recovery. By the 1960's, groups were a part of the practice of a variety of professional disciplines, a phenomenon accelerated in no small part by a surge of popular enthusiasm for the work of psychiatrist Carl Rogers and other mental health professionals. The emergence of group methodology in the 1960's paralleled (and may have been caused by) growing disentchantment with traditional professionally centered human services that were seen as failing to address the diverse needs of various ethnic groups, rural communities, and women seeking education and support around childbirth and breastfeeding.

In the early 1970's, research fndings on the effectiveness of groups provided an additional catalyst for the use of groups as a context for education and personal development. Cassel's epidemiological research (1976) described the mediating qualities of social support on stress-related health problems and the advantage of promoting social supports rather than attempting to reduce stressors among members of a target population. Caplan (1974) described how social supports reinforce psychological and social well-being.

As parenting education programs began to blossom in the 1970's, group methodology found a comfortable home in their midst. Research on the value of the social support provided by parenting and family programs confirmed and expanded the findings of the early studies (Colletta, 1981; Dunst & Trivette, 1986; Garbarino & Kostelny, 1994), and the place of the group strategy in family support grew even more established. As early as 1983, in one of the first comprehensive listings of family support programs, 67 of 73 programs profiled listed "parent groups" as a component (Payne, 1983).

No single theoretical orientation has characterized parenting groups in recent decades. Many parenting groups were developed out of humanistic theories that believed content was secondary to process; others advanced empowerment and self-efficacy theories; and still others combined these with emerging ecological theories and insights from adult education. Some parenting groups, unfortunately, reflected the popularity of group methodology but sailed off into the parenting group "sea" somewhat rudderless.

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Barbara Young

appear to people outside the group. This recognition and affirmation can be powerful forces in helping to overcome the barriers to behavior change.

The group methodology is readily adaptable to varying levels of intensity and focus. A parent may come to a group meeting to decorate tee shirts and at the same time seek, and find support for his or her efforts to negotiate a deeply personal and complex family situation. A support group on grieving may help a parent celebrate recent success in handling feelings of anger. Above all, the group offers an ideal context for dealing with the unpredictable nature of parenting. It serves as a mediating and stabilizing force for its members.

Groups also offer parents the possibility of personal connections that endure well beyond the life of the group. Many parents who meet regularly to address issues of raising infants and toddlers stay in touch during the school age years, seek each other's support in coping with the challenges of raising adolescents, and even continue their communication as they negotiate new relationships with their young adult children. Often these enduring relationsihps reflect the experience of people finding kindred spirits in the group. Other relationships may grow from the group's capacity to address practical needs (babysitting exchanges, information about best buys on diapers and toys, recommendations of local child care centers or educational resources).

A community of learners

Parenting groups lend themsleves to the creation of a community of learners. They encourage high levels of involvement, with each participant developing a personal stake in the process. They integrate principles of adult education, like active learning and the use of participant-generated information, examples, and stories. They resist the hierarchical structure of teacher as "expert" in favor of more democratic forms of facilitation and teaching/learning partnerships.

Group norms of reciprocity and shared power create opportunities for parents to claim their strengths and view themselves as teachers as well as students. The parent who lives alone may become a resource to the parent whose partner is rarely home. The parent who has successfully negotiated with a community resource may become an inspiration and mentor for a less assertive parent. And the parent who describes a challenging situation may elicit responses from participants that broaden everyone's ability to imagine more creative options and possibilities.

With a wide range of appropriate activities and formats to choose from, parenting groups can offer opportunities for practical skill-building as well as emotional learning. Groups can incorporate role plays, craft projects, celebrations, rituals, simulation exercises, and external assignments. Formats can include pairs, triads, small groups, and the whole group, as well as meetings with children and without them. The only limitations are budget, vision, leadership, and relevance to the group goal.

Parenting groups: The essential ingredients

There are many different ways to help parents overcome isolation, support each other, learn skills, and develop insights. How a parenting group sets its own priorities and goes about addressing them will depend on the choices made about several ingredients common to all parenting groups. These are: membership; duration and frequency of meetings; content and format; facilitation; and sponsorship. A smooth blending of ingredients is likely to result in a successful parenting group. When key ingredients do not mix well, are not combined in appropriate proportions, or are lacking altogether, a recipe for disappointment may be the result. In discussing essential ingredients of parenting groups, we will point out the consequences of critical choices.

Membership

Participants in parenting groups represent the universe of individuals providing care for children. Groups range in size from four or five to 25 to 30 people; on the Internet, "virtual" groups of parents are forming. Rules governing membership in a parenting group also vary: some are open to all comers, while others are highly restricted. What constitutes a group's optimal size and criteria for membership depends on the target audience and goals of the group. These choices — and the locus of decision making — have important consequences.

Consider, for example, the issue of voluntary versus "mandated" participation in a parenting group. Groups designed for education or promotion are most effective when participation is voluntary. Each participant controls his or her own decision to be present and in so doing becomes an active member in the community of learners. Participants who are mandated to attend par-

enting groups by the courts or by mental health and child welfare systems change the dynamics of the group. Attending to their needs can complicate the messages about a "strengths-based" philosophy and may compromise the goal of building a web of supportive relationships.

The tendency to mandate participation in groups is growing, however. As public agencies and private sponsors are frustrated by the cost, complexity and uneven outcomes of traditional services, parenting groups offer the illusion of a less expensive "quick fix." But there is little evidence to support the idea that a strategy to promote strengths can serve equally as well for remediation.

When remediation is the overall goal, parenting groups can be offered as an integral part of a more comprehensive and intense intervention. This approach may require sponsors to make longer-term investments, limit group size, hold frequent meetings, and offer skilled leadership. Another alternative used successfully by mental health and child protective programs is to actively support parents as they participate in comumunity-based parenting programs. This may require that a staff member accompany a parent to a group, advise the group facilitator about the most effective ways to engage the parent or, in some cases, spend time with the parent before and after the group, assisting in the integration of new information and skills. In this approach, parenting groups can help address typical developmental needs and skill-building while other methods are used to address more complex psychosocial and emotional needs.

A note on home visitation

Increasingly, parenting groups are offered as a complement to home visiting programs. The latter offer many advantages (attention to the ecology of the family setting and their adaptability to highly individual or intense personal needs), but they also run the risk of reinforcing the isolation of the parent, a major concern in child abuse prevention efforts. Not surprisingly, we are seeing more and more programs add or give greater emphasis to parenting groups as a necessary accompaniment to home visitation strategies. This combination of methods is promising, but it is still some distance from seeing its potenital realized. There are programs who have yet to appreciate or implement a knowledgeable balance of the two (growing from the goals of the program and the perceived needs of the target families). Further complicating this challenge is the lack of adequate attention to the consistency of the information these two strategies present to parents.

Duration and frequency of meetings

Parenting groups vary by session length, frequency, overall duration, and intensity. Possible combinations are almost endless; the term "parenting group" can cover a single two-hour session on self-esteem, an eight-session series on effective discipline, or a year-long weekly gathering for mothers experiencing post-partum depression. Some parenting groups get started in response to a specific need or set of circumstances and continue as long as interest is high (a common description of grassroots efforts that last several months). Other groups define an endpoint at the outset and use group process concepts of "beginning, middle, and end" to maximize the effectiveness of the method.

Although single-session or short-term designs are popular, an "inoculation" approach has never been shown to help parents cope effectively with any key parenting issue. Sponsors or organizers should consider the advantages of parenting groups offered consistently throughout the year. A period of 6-8 meetings over as many weeks seems to be the minimum time required to create the conditions of success — like the building of a degree of trust among members — through the group process. This statement does not imply that parenting programs of shorter duration should not be offered; rather it means that these efforts should be designed and promoted as "classes" or "workshops" rather than as "parenting groups." Greater clarity would help both the leadership and the participants develop more appropriate expectations of the program and each other.

Content and format

Approximately a dozen national parenting programs adhere to a standardized curriculum. Most parenting groups, however, mix and match components of several curricula. Groups often incorporate their own innovations to reflect the cultural norms and learning styles of their target group or make adaptations based on the goals of the sponsoring organization or the talents and interests of the group facilitator. During the many years when no published curricula for parenting groups existed, participating parents were always "designers" of their groups' content and format. Today, some programs explicitly value parent-generated content in contrast to standardized curricula.

Integrity should be a prime concern in making choices about content and format. Parenting groups — as distinct from, say, a class in child development — tend by their very design to undermine efforts to control and focus power. For sponsors with a traditional "teaching" agenda, a classroom setting with interactive exercises would more effectively shape participants' expectations and probably be more effective than a parenting group. Too rigid a format or a heavily didactic agenda imposed on a parenting group is likely to frustrate participants and facilitator alike; frequently such a group fails before the leadership realizes what has happened.

Facilitation

Facilitators of parenting groups have always included both volunteers and paid staff. Facilitators include peo-

Marilyn Nolt

ple with little or no formal education and holders of post-graduate degrees in health, human services, psychology, and education. The range of level of expertise and experience in group leadership is equally broad. Some parenting group designs require co-facilitators; some require facilitators to be parents themselves; and still others place a priority on culture, ethnicity, and/or race as qualifications for facilitators.

Because content and process are so intertwined in a parenting group, it is no easy task to find a facilitator equipped to meet all of a group's needs. The culturally competent facilitator with a rich store of experience as a parent, for example, may not come with the "bifocal vision" required to monitor individual and group process. The group leader who is well-versed in child development may have difficulty shifting roles from "teacher" to "facilitator," from "authority" to "enabler." Serial "guest facilitators" (often volunteers) may be knowledgeable in their areas but are unlikely to nurture relationships within the group or attend to issues of reciprocity and shared power. The facilitator who has been trained to implement a specific curriculum may have technical skills honed at the expense of developing flexibility and responsiveness to parents' needs. Group facilitators who seek to work with parents who have multiple and complex needs require special training and support; to be successful, they must learn both to recognize and provide the intensity of service that such a target group demands.

Generic training could better prepare parenting group facilitators to meet the many, diverse needs they are likely to encounter, but such training is seldom available. A few states with certification programs for "parenting educators" or "family life workers" include group leadership as one of the skills to be mastered. Several national parenting programs that employ the group method have formal, model-specific facilitator training programs, supported by train-the-trainer programs. Nationally replicated models often recognize the tension in their training between the need to assure curriculum consistency and the desire to prepare trainees to make the necessary adjustments each group demands, knowing that the latter cannot be accomplished without good (and expensive) ongoing supervision. A small number of degree-granting institutions include preparation for leadership of parenting groups as part of their more generic family support training. Many professional practitioners use in-service training, mentorship, and continuing education programs to help develop and/or mature their skills in parenting group leadership. The largest group of facilitators, however, relies on "learning-by-doing," supplemented by occasional workshops.

Critical questions about recruitment, selection, and development of staff for parenting groups must be framed within the broader context of family support. Debate continues over whether family support is an approach, a field of service, or a program model, and questions persist about the core competencies needed by staff of family support programs. The field lacks guidelines for understanding the relative effectiveness of different parenting group designs, their appropriateness for achieving different agency and participant goals, and the level of professional, paraprofessional, or voluntary leadership required by each design. Without generally agreed-upon guidelines to help program planners and facilitators create good matches between groups and facilitators, it is likely that staffing decisions for many parenting groups will be driven by convenience or funding constraints.

We believe that regular supervision and in-service training are essential to ensure the quality and nurture the "art" of parenting group facilitation. Recognition of the importance of supervision is still far from universal, however. Sponsors do not question the need to monitor attendance and coordinate schedules, but it is unusual for programs to allocate time, money, and staff so that parenting group facilitators have regular opportunities to reflect on their practice, as recommended by ZERO TO THREE (Fenichel, 1992). Continued efforts are needed to identify and describe successful models of facilitator supervision — individual, group, and peer — particularly among financially strapped programs. Efforts are also needed to: reveal how models of facilitator supervision operate within agency settings and for more independent groups; delineate the complexities of the supervisory relationships and its parallels with the facilitator-parent relationship; and continue to identify and develop training opportunities for supervisors.

Sponsorship

Sponsors, funders and sources of legitimacy for parenting groups are many and varied. They can include any number of government bodies and agencies, hospitals, child care programs, early intervention programs, grass roots community groups, schools, religious institutions, correctional facitilites, residential drug treatment centers, and, of course, parents themselves. Any sponsoring organization will have its own assumptions (explicit or implicit) about parents' needs and biases about what works to help them. Decisions to establish a parenting group may reflect a series of increasingly questionable assumptions — for example, that changes in parents' attitudes and behaviors will result in significant improvement in children's developmental outcomes, or that mandated attendance in a parenting group will bring about exactly those changes in parents' attitudes and behaviors that the sponsoring organization desires, or that a time-limited group led by an inexperienced facilitator will be bring about desired changes in a group of parents with multiple and complex needs.

While parenting groups often benefit from the extended resources and broad capacity of a sponsoring organization, the nature of the sponsorship may also limit the effectiveness of the group setting. For example, workplace parenting groups have to overcome participants' reluctance to have co-workers — or supervisors — learn about the challenges they are facing with their children. Parenting groups sponsored by branches of the military may have to adhere to the established disciplinary system for reporting on a parent/soldier's behavior. Schools must work hard to overcome a reputation for marginalizing parents' importance in the educational process. And groups sponsored by child protective services can be undermined by the perception that they serve only "troubled" parents, or by the tendency to blur distinctions and confuse otherwise normal parenting issues with feelings and behaviors that might put the parent at risk of intervention.

The effectiveness of group methodology is premised upon the ability to build and maintain trust among group members. The ease with which trust is established may be positively or negatively affected by realities or perceptions of the sponsoring agency itself. Sponsors' decisions about other ingredients — membership, duration and frequency, content and format, and facilitation — will affect the maintenance of trust and the ability of the group to accomplish its goals.

Conclusion

Parenting groups have established themselves as a staple of parenting education and family support programming. Their accomplishments are impressive, and their enthusiasts are, not surprisingly, many. Yet as appealing as parenting groups are, and as effective as they can be, we must acknowledge their limitations and begin to wrestle seriously with the challenges they present. As individual practitioners, administrators, and trainers, and as a field of practice, we must examine the integrity of the parenting group method, question the rationale for decisions governing its use, and clearly define the issues of quality assurance that emerge in the preparation and ongoing supervision of facilitators.

A great deal more research is necessary to help us all understand the dimensions of effectiveness and appropriate use of parenting groups. Organizations like MELD (see Hoelting et al., this issue) that have begun to address these issues need to be applauded for what they have done and encouraged to do more. Meaningful evaluations of ecologically grounded efforts like parenting groups are not easy to design or implement. Nevertheless, we call on practitioners to do a better job of documenting their work, on programs to appreciate the importance of evaluation, on researchers to "press the envelope" in helping to design new measures and qualitative approaches, and on funders to enable all this to occur.

Another challenge for the field is integrating group methodology into the comprehensive array of services we offer to families. Exploring ways in which group strategies can complement and support other strategies is, we believe, a compelling priority.

Parenting groups are, in sum, a necessary and valuable strategy for serving parents well, as long as their sponsors and leaders remain aware of groups' limitations and the circumstances in which groups are most effective. We celebrate the contribution of parenting groups and the ways in which they symbolize (and deliver) the promise of the family support movement.

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The MELD Experience with Parent Groups

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Since 1973, **MELD** (formerly Minnesota Early Learning Design) and its affiliated agencies have provided group-based parenting education to thousands of parents in 25 states. A national private, not-for-profit family support agency, funded by a variety of grants and fee-for-service contracts, with headquarters in Minneapolis, MN, **MELD**'s ongoing mission is to strengthen families in critical periods of transition. The **MELD** approach brings together groups of parents who have similar needs, provides them with pertinent information, and helps them to develop into supportive peer groups.

The informal and formal learnings about **MELD**'s use of groups to deliver parenting education are significant for several reasons:

- Research has identified isolation as a primary factor in child abuse and neglect, giving validity to the use of groups to address family needs.
- **MELD** has taken an in-depth approach to group-based parenting education much longer than most parent support programs. **MELD**'s tested tools and methods can be implemented by others who are seeking ways to make parent groups work.
- Since the late 1970's, **MELD** programs have been replicated by almost 200 agencies, including hospitals and health clinics, schools, family centers, child care centers, job training centers and community-based not-for-profit groups.
- **MELD**'s experiences are not limited to a single population. At the request of parents and the professionals who serve them, **MELD** has customized its group approach for eight parenting populations.

Development of the **MELD** model began in 1973, when founder Ann Ellwood reviewed literature, surveyed needs, and assessed resources related to young children, parenting, and early learning. The program design was piloted from 1975 to 1978 with five parent groups, which included nineteen Parent Group Facilitators and 89 parents.

Throughout the 1980s, **MELD** developed programs to meet the unique needs of specific populations, usually at the request of communities and related agencies serving these populations. Currently, **MELD** offers eight programs:

- **MELD** for Young Moms: teenaged mothers of children in the last trimester of pregnancy through age two years;
- **MELD** for Growing Families: young mothers of children aged 3 - 5 years;
- **MELD** for Young Dads: men 14 - 25 years old who are fathers of preschool children;
- **MELD** Special: parents of children with special needs, from birth to three years;
- **MELD** for Parents who are Deaf and Hard of Hearing: parents of children from birth to three years (children may or may not be deaf themselves);
- **MELD** para Nueva Familia: Latino and bi-cultural Hispanic parents of children from birth to three years;
- **MELD** for Hmong Parents: Southeast Asian immigrant families of preschool, school-aged and adolescent children;
- **MELD** for New Parents: adult parents of children from birth to three years.

MELD program description

Philosophy and goals

The four **MELD** philosophy statements are evident at every group meeting and at every training session: "We can learn from each other. We can support each other. We can cooperate with each other while maintaining our individuality. We can make informed decisions." This philosophy is woven throughout the group discussions and activities as parents discuss their concerns and achievements. As the group process works over time, parents become more self-assured and promote family wellness (Ellwood, 1988).

MELD's impact lies in mediating factors related to the potential for child abuse and neglect:

1. Family isolation is reduced through the support of other parents and through improved connections with community resources.

Barbara Young

2. Parents increase their knowledge about child growth and development and age-appropriate behavior.

3. Parents become skilled at solving problems and making decisions that support their own health and well-being, as well as those of their child.

The **MELD** curriculum is customized for each target population and deals with many aspects of family life, including the life experiences, family strengths and parenting concerns that were identified by parents in the program's pilot groups. The material also integrates the general information parents need about child development, child guidance, health, family management and parent development. Results of parent satisfaction surveys show parents' appreciation for the warmth and respect with which **MELD**'s learning activities encourage interaction with group members and with their children. "We had been looking for a support group for a while, but most of what we found didn't meet our needs. **MELD** was a great place to meet with people who are having the same experiences with kids with special needs . . . they understand . . . The whole experience has been so good for our family," reported a **MELD** Special parent.

In every **MELD** community and target population, the program is recognizable through the replication of these essential program components:

- group facilitation by parents who have experienced life situations similar to those of group members;
- long-term availability of programming (generally two years);
- an approach that integrates information into a supportive group environment;
- program content that addresses the concerns of the group, the parent, and the child;
- a persistent focus on parent strengths;
- an emphasis on how to solve problems and make decisions, rather than a focus on the "quick fix"; and
- a strong emphasis on supporting volunteers and professionals through ongoing training and technical assistance.

MELD's meetings are held weekly or bi-weekly in community-based settings. Each **MELD** meeting lasts two to three hours. Meetings begin with a meal or snack to allow for informal interaction among parents, Facilitators and children. The formal meeting begins with a time for parents to discuss current issues, problems and successes. The last part of the meeting is a learning activity, typically from **MELD**'s curriculum, focusing on an issue selected by the group. The group selects discussion topics every ten meetings, and also establishes its own norms and rules. Groups take a break after every 10 meetings and allow time for Facilitators to receive additional training to prepare for the coming phase of service

Staffing and training to replicate the program in affiliate agencies

After an agency has decided to replicate the **MELD** program, the agency develops a budget allowing for the following costs: 1) operational costs that assure program success, including a small stipend for Parent Group Facilitators, child care, food, and transportation, 2) salary for a Site Coordinator who will have primary responsibility for replicating the program, 3) administrative costs to operate the program, 4) **MELD**'s replication fee for training, technical assistance and program materials, and 5) **MELD**'s licensing fee.

The paid **MELD** Site Coordinator manages the implementation, maintenance and evaluation of a local **MELD** program. The Site Coordinator is also responsible for the recruitment, training and supervision of the volunteer Parent Group Facilitators. The qualifications for a Site Coordinator include knowledge of a content area such as social work, psychology, family social science, child development, education or health; at least two years of experience in programs working with families; experience working with the culture or population served by the program; experience supervising personnel or volunteers; experience with public speaking; experience as a volunteer; and knowledge of community leaders and programs.

The Site Coordinator is trained, supervised, evaluated and certified by a Program Replication Manager from **MELD**'s national headquarters. During the first year, Site Coordinators receive 40 hours of basic training, 18 technical assistance phone calls, and 40 hours of on-site consultation. Among other things, the **MELD** certification allows Site Coordinators to conduct **MELD**'s training for Parent Group Facilitators in their community. After certification is accomplished, a continued relationship with **MELD** central allows for technical assistance about ongoing issues in program maintenance, training and certification of new and additional Site Coordinators, and networking with other **MELD** programs around the country. Only programs affiliated with **MELD** are licensed to use many of **MELD**'s program management tools and materials.

Parent Group Facilitators are community-based volunteers who work in teams with the parent groups. Parent Group Facilitators typically are provided a stipend for their out-of-pocket expenses. There are no educational requirements, and candidates are as likely to emerge from among local bank employees as from a local service agency. Site Coordinators provide Parent Group Facilitators with over 100 hours of training and supervision throughout the two years.

Community linkages also stimulate some in-kind staffing and contributions from local partners who let groups meet at their facilities, provide advisory committee members to the program, or volunteer other types of program support.

Peers-by-experience as Parent Group Facilitators

I don't need another professional in my life. I want somebody who has gone through the same things I'm going through. — **MELD** Special Parent

MELD has developed a model for peers-by-experience to lead groups because of a belief that peer support can play a very unique role in the lives of parents. The importance of these "paraprofessionals" cannot be underestimated. Therefore, careful recruitment and selection, thorough training, and consistent supervision are responsible and beneficial ways to assure program effectiveness.

MELD strongly believes that "peers-by-experience" reflect the lifestyle, the parenting experience and the culture of the parents in the **MELD** group. They speak to parents with integrity. **MELD**'s philosophy, "We can support each other. We can learn from each other," speaks to the belief in the capacity of both the Facilitators and the parents. **MELD** believes that professionals are capable of making significant contributions to parent groups, but that peer Facilitators do this work in qualitatively different ways. For instance:

- A deaf Facilitator working with parents who are deaf and hard of hearing has said, "The parents in my **MELD** group feel comfortable and participate freely. No interpreters are needed. And I want to contribute my abilities, skills and enthusiasm." The same holds true for Southeast Asian or Latino parents who are able to receive parenting information and support from Facilitators who speak their primary language.

- In a group where culturally appropriate Facilitators are present, there is a depth of self-disclosure that precipitates productive and culturally-specific solving of problems.

- Parents with similar needs have already negotiated a myriad of services and professionals that the group members will encounter. They provide a much needed perspective and role model for coping with difficult circumstances and using services available in order to survive and progress.

Parents identify their peer Facilitators as an important aspect of **MELD** groups. One evaluation noted that parents in the **MELD** for Young Moms (MYM) program were very positive about the MYM groups and Facilitators. Participants described MYM as offering a lot of critical information about parenting as well as much needed emotional support. Facilitators were named consistently by the teens interviewed as being a primary source of information, services and referral (Constantine, Aronson, & Branagh, 1994). Another evaluation report stated that, "While professional counselors can be excellent and effective group Facilitators, our observation leads us to conclude that choosing Facilitators who are 'close' to the youth either in terms of age, cultural, or ethnic background or life experience might be

more effective than selecting based solely on professional credentials" (Kotloff, Roaf, & Ma, 1993).

Assets of "paraprofessional" leadership include the following:

- Their selection functions as an investment in the community because it provides useful training to community members.
- Their knowledge of and involvement in community networks hastens the establishment of trust.
- Costs related to using community-based "paraprofessionals" are lower, making them affordable for settings that otherwise might not be able to hire an equivalent number of family workers (Family Impact Seminar, 1996).

Recruitment and selection

MELD's peer Facilitators are known as Parent Group Facilitators. Site Coordinators recruit potential Parent Group Facilitators through a community development plan and recruitment system. Networking is essential, so contacts are made with agencies who serve the target population, including civic organizations, churches, colleges, and volunteer centers. Media opportunities are used. Word of mouth referrals are, of course, essential. Often, former participants of family support programs (including **MELD**'s program) are recruited because they want to "give back" to the program that strengthened their family. According to a Parent Group Facilitator for a **MELD** for Young Dads group,

I became a father at the age of 17. I was frightened, confused and uncertain . . . It seemed that society expected me to fail. I want to tell young dads who have an active role in their child's life that they have my deepest respect and admiration. I know the road into the future may not be easy, but they can succeed.

MELD Facilitators are always paid a stipend for related expenses to enable parents of any income group to volunteer. Parents respond very positively to someone who "isn't being paid a salary" to care about them, especially when their lives are filled with other professionals. A recent report on **MELD**'s peer group relationships noted that "the young women spoke appreciatively of their Facilitators and interpreted the fact that Facilitators were unpaid as a sign of genuine commitment" (Kotloff, Roaf & Ma, 1993).

Facilitators give between 300 and 500 hours of time to be recruited and trained and to plan and conduct meetings. Successful recruiters describe realistic time commitments. When this significant commitment is downplayed, Facilitators may eventually feel misled and resent the time requirement.

Volunteers are often interested in the benefits of the position. Some Facilitators have received college credit. Others use the skills gained in their current work. One Facilitator, a college professor, said, "Don't ask me how

MELD

being a teacher helped me become a Facilitator. Ask me how becoming a **MELD** Facilitator improved my teaching." Still others have used this volunteer work as a basis for future employment. Many Site Coordinators around the country have come from the ranks of program volunteers. Letters of recommendation outlining skills and experiences job candidates have gained through their volunteer experience may be provided to future employers. Facilitators often describe how it has helped them in their own role as parents. According to Toua Thao, a Hmong Parent Group Facilitator from St. Paul, MN, "You have to have your own house in order, or parents will not respect you, and this experience helped me as a parent." This process of personal development becomes a secondary effect of the **MELD** program. Facilitators experience tremendous growth during their two- year commitment.

The selection process is critical. **MELD** Site Coordinators look for Facilitators who are non-judgmental and open to others' lifestyles and experiences. Women and men who have experienced difficult life circumstances such as depression, poverty, abuse or addiction can be excellent Facilitators. However, if they are currently experiencing problems, it may be unrealistic to expect that they can consistently plan meetings, attend training, and lead group meetings. Moreover, when Facilitators lack support systems in their lives, they are often not able to provide needed support to parents. They may eventually rely on the parent group for their own support needs.

Teams of two "families" (either couples or single parents) are recruited as Facilitators for each group. The Site Coordinator creates "teams" among those recruited so that individual styles complement each other and so that parents are assured that various choices can be successful. Teams who feel comfortable with one another and share responsibilities equally are most likely to follow through on their two-year commitment. They have higher group attendance and develop well-functioning groups.

Potential Facilitators are screened using a formal application and interview process which reinforces the importance of the work. The candidate completes an application to provide background information regarding work, school, family and life experiences. Interviews are held in the candidate's home so that Coordinators observe the parent managing home and family. This also provides a comfortable setting for establishing the working relationship. The Site Coordinator's goal is to gain insight into the candidate's strengths and biases in order to understand what they will bring to the group and what might be achieved through training and supervision.

The selection process for the Parent Group Facilitator is intended to avoid future problems. Two common mistakes are feeling desperate for a body to fill a position and feeling uncomfortable about turning down a willing volunteer. Coordinators get technical assistance from their MELD Program Replication Manager as they handle such predicaments.

Facilitator training

The MELD Site Coordinator seeks candidates who will respond well to training and supervision. The initial preparation of Facilitators requires twenty hours of training, adapted for the various target population. The training clarifies roles and responsibilities so that trainees understand what is expected of them in the MELD group. Training includes an overview of the MELD program; group coordination (planning group meetings facilitation and group dynamics, problem-solving skills and responding to physical and emotional needs); providing support (understanding and practicing supportive communications) and delivering information (becoming familiar with MELD's curriculum). Training goals include:

- To clarify the role of the Facilitator;
- To model facilitation skills and delivery style;
- To clarify what the MELD approach is capable of doing;
- To practice skills and activities to use in the groups;
- To create an effective group among trainees, modeling the development of "group feeling" while providing a support system among Parent Group Facilitators;
- To coach Facilitators in how to use the MELD curriculum;
- To allow the Site Coordinator to observe the specific styles and strengths of individual Facilitators and to prepare for supervision strategies;
- To help Facilitators analyze group settings and their effectiveness.

Supervision

Close and supportive supervision of Facilitators is provided by MELD Site Coordinators in order to ensure group quality while minimizing professional intervention in the group's experience. Supervision guidelines call for weekly calls, regularly scheduled planning meetings, group observation visits, ongoing training and performance reviews. As competence increases, less frequent phone contact and group observations are required. This system motivates and lifts spirits which helps Facilitators maintain their commitment. Formal performance reviews are completed once a year.

During conversations with Site Coordinators, Facilitators can be forthcoming about frustration in a safe place. Together, they get resources and assistance for planning future meetings. It is important that these sessions model the same sort of exquisite respect for the volunteer that the program expects volunteers to provide to parents. Without ongoing support and feedback, small problems can increase and become detrimental to parents in the program.

Program Replication

Everyone is telling me that family empowerment is important. Nobody is telling me how to do it—a potential MELD replication site staff member

Replicating a program model is a process of blending practical information and management tools with the values that make the program recognizable. Over the past twenty years, MELD has discovered that groups can be implemented by a variety of health, education, welfare, family support agencies. Private, non-profit, government and community-based organizations have replicated MELD in communities across the United States. However, matches between MELD and its affiliates are not always "made in heaven," and agencies face a number of practical considerations as they translate philosophy into practice. An ongoing relationship with MELD's national headquarters helps agencies track their progress and maintain the credibility of the program's philosophy and values.

MELD's founder discovered that the program's concepts resonated with professionals who called for assistance in replicating. "I remember," says Founding Director Ann Ellwood, "after we decided to replicate, the hardest thing was figuring out how to unbundle what we did. We had to articulate the integral parts that pulled our groups together, as well as the means by which we conveyed respect and encouragement to parent groups." Therefore, the words MELD puts on paper

through curriculum, training scripts and management manuals are consistent with the values of the program: They ask before they tell. They promote shared decision-making and problem-solving. They appreciate that there is no single "right way."

Training to create authentically accepting, supportive learning groups requires more than setting these words on paper. As **MELD** provides practical, factual information through training and ongoing relationships, the values that make the program emotionally beneficial to parents are transmitted. **MELD**'s training and technical assistance help **MELD** Coordinators develop productive community partnerships, recruit appropriate Parent Group Facilitators, conduct successful volunteer trainings, recruit parents into the group, and maintain and evaluate a quality parent education program over time. **MELD** encourages trainees to understand why certain practices are used and helps Coordinators to consider the effects of interactions with Facilitators, parents and community members.

"Red flags" for the replication relationship may become apparent during the pre-contract phase. Appropriate expectations of the relationship are articulated and, if differences are great, the relationship might end before there is unnecessary expenditure of time and money. In some cases, the agency might choose short-term training from **MELD** that more appropriately addresses an agency's goals, rather than fully replicating **MELD**'s program goals and methods. Four issues that commonly arise in program replication include: 1) lack of commonality regarding philosophical bases for service delivery; 2) lack of time for program management; 3) difficulty in replicating each of **MELD**'s essential components; and 4) lack of integrative relationships among the **MELD** program and the agency's other programs.

When all the components are in place, replicating the **MELD** program is a smooth, step-by-step process: 1) sign the contract with **MELD**; 2) choose a Site Coordinator; 3) attend **MELD**'s initial five days of training; 4) prepare the community for the program; 5) recruit Facilitators and parents; 6) train Facilitators; 7) begin the first groups; 8) keep the groups going; 9) get certified by **MELD**; and 10) maintain an ongoing affiliation with **MELD** in Minneapolis. When challenges arise, the trust between the site and the national **MELD** office stimulates effective problem-solving through technical assistance by telephone, site visits, and annual conferences.

Philosophical match

Words used to describe family support principles are at risk of becoming cliches, void of authentic meaning. Any agency may claim the principles, even if practice is inconsistent with those statements. Members of several coalitions, such as The Family Resource Coalition's Best Practices Efforts and New York State's Family Support Credentialling Project, are contemplating whether quality control efforts can effectively translate philosophy into action. This issue has implications for **MELD**'s repli-

cation process as well. Much of MELD's work with sites is done "long-distance." Program Replication Managers often ask, "What do you mean by that?" as a critical part of finding common ground between MELD and the agencies implementing its program around the country.

Sometimes, differences in work styles reveal dissonance among philosophies. People who do not understand the role of "solving problems and making decisions," for example, may undervalue the ways in which MELD provides technical assistance. While MELD has developed many effective techniques, there is always value in the expertise local Site Coordinators have about their community. Therefore, MELD Program Replication Managers analyze situations and consider the site's expertise, rather than "give answers" about what is best for the community. This is consistent with the practice used by Site Coordinators and Parent Group Facilitators with the parents as they bring expertise about their child into MELD parent group discussions.

Site representatives may see the process of analysis and use of agency context as a time-consuming luxury. The investment of time may be less efficient than "doing as you are told," but it helps the Coordinator build a foundation for the program to be responsive in their community.

Quantity of time

MELD recommends that a full-time Site Coordinator manage four groups, especially when programs are working with highly stressed parents. Four groups requires organizing programming for approximately 80 parents and 8 to 12 volunteers. When parents have specific needs rather than multiple personal, family, and/or financial challenges (e.g., parents of children with special needs or parents who are deaf), one full-time person can oversee at least eight parent groups with approximately 160 parents and 24 to 30 volunteers. For even less-stressed parents (e.g., first-time adult parents of newborns), a full-time manager can handle 16 groups serving approximately 300 parents with 56 volunteers.

This management level allows time for development of a resource and referral system, identification and preparation of appropriate Facilitators, and quality group organization. When MELD Site Coordinators are pressed to focus on "numbers" rather than "investment," program quality can suffer. Moreover, when the MELD program is simply added to an already full job, program goals may be impossible to achieve. Recruitment, group attendance, and ultimately program outcomes suffer.

MELD Program Replication Managers work with agency supervisors to determine the goals for the program, to clarify restrictions placed on the Site Coordinator, and to review the guidelines outlined in the contract regarding time needed to implement a MELD program. MELD's technical assistance can help with ways to prioritize tasks, mobilize volunteer assistance, share their work with other staff persons, or reduce the number of groups offered. In these circumstances, the best-case scenario would be that over time the benefits of the MELD program cause communities to actually increase time spent building parent groups. In worst-case scenarios, MELD adapts its expectations for agencies and informally views sites as "partial replications" of the program.

The essential components

MELD programs are recognizable through the essential components. When sites wish to modify or change the essential components that define the MELD program, reasons and the effects of altering the model must be explored. How many deviations can occur and still retain a recognizable MELD program? Will the essence of family support still be evident? Are there other strategies that can achieve the same goals just as effectively? Discussions about the intent of the program modification often generates alternatives that will retain the essential elements while adapting the MELD program into the community.

It is important to determine if the reason for deviating from MELD's model is a differing philosophy or a lack of success in implementation. When the obstacle is philosophical, MELD's national staff suggests ways to overcome the differences. When the reason is simple frustration due to lack of success, technical assistance provides tools and methods that overcome the problem.

Peer leadership is one essential component from which Site Coordinators sometimes deviate. When Site Coordinators begin to "opt out" of recruiting peers-by-experience, MELD's technical assistance keeps agencies on track with the original goals of their original program goals. Do Coordinators lack faith in peers for this important task? If so, we must review the philosophical underpinnings of peer support and the expectations of a peer Facilitator. Has it just been too difficult to recruit

Essential Components of the MELD Program

- Groups of parents with similar life experiences whose children are the same age.
- Peer Facilitators -- someone who "has been there"
- Long-term service delivery (two years)
- Blending information and support
- Curriculum focuses on the parent, the child and the group
- An emphasis on solving problems and making decisions
- Builds on parents' strengths
- Strong emphasis on training and ongoing technical assistance for professionals and for Facilitators

Facilitators? Brainstorming can generate new ideas for recruitment and publicity. Has the Site Coordinator had negative experiences in the past with peers who were irresponsible or too stressed to be effective? Methods for selecting appropriate Facilitators and maintaining quality control can help the Site Coordinator.

Similarly, **MELD**'s model encourages parents to use a variety of services to achieve goals and encourages the establishment of effective community collaborations and resource and referral systems to increase a program's capacity to serve parents. Busy Site Coordinators may not encourage this community involvement. Their past experiences may lead them to believe that advisory committees and referral systems are "more work that they are worth" and that it is easier to "just do it yourself." However, groups may simply not offer enough support for some highly stressed parents. If groups are expected to be a panacea for complicated life circumstances, they will certainly fail to meet agency's expectations. When agencies have many services internally to offer parents, there is a large temptation to eliminate the community development portion of the model. However, parents do not live in a vacuum; the **MELD** program must reflect the concerns and culture beyond the agency's walls. The benefits of stimulating community visibility must not be overlooked. Programs need the support and endorsement of their entire community to progress.

Program integration

MELD's training supports Site Coordinators in "selling" the program to relevant persons within their own agency. **MELD** invites (and all but requires) directors of agencies to attend training along with the Coordinator so that the "big picture" of the agencies' needs and possibilities can be brought into the program development plan. This is important to the process of integrating a **MELD** program within the myriad of agency efforts. Many agencies expect all the programs they offer to be free-standing and independent. Thus, publicity, fundraising, grant reporting, evaluation and volunteer recruitment efforts are duplicative and become more expensive than necessary.

Integrating group-based and home visiting parent education programs

We're finding that home visiting isn't enough . . . —a family center director

The growing demand around the United States for home visiting programs is a promising sign of progress for the family support field. The work of the National Committee for the Prevention of Child Abuse (NCPCA), Home Instruction Program for Preschool Youngsters (HIPPY), Parents as Teachers (PAT), and many efforts in the public health sector has resulted in the proliferation of home visiting programs and influenced public funding for home visiting programs. Some initiatives, though, have found that the addition of parent-to-parent group activities can be used to strengthen outcomes. "The parent group meeting is one of the major components of the HIPPY model. The group meeting should be an enriching event for parents and staff, and should result in positive outcomes for all" (Johnson, 1996). Integrating group-based and home-based programming may combine the "best of both worlds." In practice, though, agencies often have trouble making programs equally successful or focused. Training, administration, joint programming and information-sharing are all important to successful integration.

MELD's group model has been placed beside home visiting programs throughout Illinois and Arkansas, as well as in many other communities around the U.S. In Philadelphia, **MELD**, when integrated with a home visiting program, was one of two programs which had significant improvements in impacting factors that predict child abuse and neglect (Daro, Jones, & McCurdy, 1995).

In 1994, **MELD** staff began to focus even more attention and analysis on linking its group-based programs to home visiting initiatives. Through a partnership with The Ford Foundation and Virginia's Comprehensive Health Investment Program, **MELD** is examining appropriate steps for integrating the two approaches. Future analysis will describe integration methods including:

- Staff development: Joint training for home visitors and Parent Group Facilitators can support common goals and practices and shared workloads. **MELD** has developed training to help all workers "get on the same page" regarding roles and responsibilities. Initial trainings are most effective when followed with formal and informal ongoing training and communication. Together, home visitors and group facilitators can address similar professional development goals, especially those related to competencies in family support principles.

- Program administration: Internal and external communications should present both approaches as equal in status and value. Moreover, supervisors of both programs should have equal status, pay and responsibilities within the organization.

- Program components: Home visitors and group facilitators should both attend the various activities sponsored by the agency. This illustrates to parents that these are actually a single program, not two. Common evaluation tools articulate and examine the goals the whole agency hopes to achieve. In this way, parents do not have to spend time with duplicative forms, and the program can integrate its understanding of outcomes.

- Information and resources: Group facilitators and home visitors are both important resources in helping parents overcome difficult life circumstances and achieve goals. Group facilitators and home visitors should share information about parents receiving ser-

vices when such knowledge will enhance the level of support and information parents receive to solve their problem. Since there is a risk that this may result in "gossip," workers must, with integrity, observe standards of confidentiality.

Eventually, the report on these MELD experiences will further examine these options and include feedback from parents, volunteers and professionals about responses to both programs. In the final analysis, what we learn will also give input to MELD's replication procedures in communities where MELD and home visiting programs are linked.

Evaluations of the MELD Program

During MELD's pilot years, formative evaluations resulted in continual changes and refinements in missions, goals, objectives and methods. The MELD staff's ability to carry out evaluations and make immediate alterations contributed to early success. MELD's priority was clearly service delivery rather than measurement of outcomes.

A 1985 study demonstrated that the amount of support MELD participants get from the program is high and that much of their support comes directly from the parent group. The only source of support ranked more highly was "spouse." Furthermore, the MELD program group was the only group among those studied with a statistically significant increase in knowledge of child development (Powell, 1993).

Summative evaluations indicate that MELD participants reduce the amount of isolation in their lives, develop appropriate knowledge, attitudes and skills related to childrearing, and make positive choices for themselves and their families.

In examining the work of its affiliate program sites, MELD has typically operated on a consultative manner, helping programs examine their own programs in relation to their organization's needs. A primary portion of MELD's program development activities for each new targeted parent population is the development of appropriate evaluation strategies. The way that parents provide feedback and information about outcomes, the types of outcomes that are measured and the validity of the results must be examined in relation to the language, needs and life experiences of the parents in the group. For that reason, MELD invests a great deal in the development of Evaluation Manuals that will assist partner agencies to measure results of their program.

MELD has recently taken a more proactive approach to evaluation. In order to examine common effects of the program, MELD is studying a cross-section of its affiliate groups. Evaluation sites in a 1995-96 study included eight MELD for Young Moms programs from urban, suburban and rural settings and various cultural communities. All mothers had a child under the age of two years and were, on average, 17 years old at the time the pretest was complete. Overall, the information collected demonstrated a significant shift in attitudes and beliefs toward positive parenting and nurturing children, as measured by a version of the Adult-Adolescent Parenting Inventory (Bavolek, 1984). These results also indicated that these parents are at lower risk for child abuse and neglect after participating in the MELD program. Specific results indicated the following:

- Mothers had more appropriate expectations of their children's abilities.
- Mothers increased their ability to be more empathically aware of their child's needs and to respond in an appropriate fashion.
- Mothers believed less strongly in the value of corporal punishment.
- Mothers realized that their child did not exist to please and love them; instead, they were there to respond to their child's needs in an appropriate fashion (Treichel, 1996).

Site Coordinators were also asked to report on educational status, employment status and rates of repeat pregnancies for all parent participants who had attended at least 50% of all meetings offered in their group during 1994. Findings for these participants indicated:

- A total of 234 participants were of eligible age to be attending a middle or high school. Of these 234 participants, 181 (77 percent) were enrolled in age-appropriate education or training.
- Of the 336 participants, 86 (26 percent) had a high school diploma or general education diploma.
- Of the 86 participants who were of eligible age to be attending a post-secondary educational institution, 46 (53 percent) were furthering their education.
- 84 parents (25 percent) of the 336 participants were employed.
- During 1994, 292 (87 percent) of the 336 participants did not become pregnant (Treichel, 1996).

Studies of the MELD Special program for parents of children with special needs indicated that the primary benefits of this program over time is the reduction in isolation and a corresponding lessening of depression for parents. Retention in MELD programming is high (90%), and parent satisfaction in the program is quite high (Treichel, 1994).

Affiliate sites have also participated in other research efforts and contributed the findings to MELD's overall understanding. Ultimately, it is MELD's obligation to demonstrate that the time spent conducting programs "in the MELD way" is valid through feedback from parents and professionals who work with the program and through ongoing evaluation. Program administrators and funders deserve to know that their investment will pay off as families are strengthened in their communities.

Conclusion

The **MELD** experiences reported by parents seem to speak for themselves:

I think it is very important that we as a [Hmong] community come together as a group and learn from each other. I have learned a lot of information from the group's members and it's helped me to be aware of my children's needs. I think ***MELD*** *groups are helpful to me because when I have a conflict with my children, I know how to deal with them.—Graduates of the* ***MELD*** *for Hmong Parents program.*

I don't know where I would be without this group. I was carrying so much anger around and did not understand why. The group helped me take charge of my life and provide a safe environment for my child.—Graduate of the ***MELD*** *for Young Moms program.*

*Our group officially ended last month after its two-year commitment. We now enter a new phase, a phase of friends getting together informally to share concerns of children and life, and to enjoy each other.—****MELD*** *Parent Group Facilitator.*

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Note: Readers wishing more information about MELD may contact MELD, Suite 607, 123 North Third Street, Minneapolis, MN 55401, tel: (612) 332-7563, MELDCTRL@aolcom

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Parenting Works!

A Parenting Group on Public Television

After five years of study and a pilot program aired in five cities, Parenting Resources, Inc. of Minneapolis, Minnesota and Blue Penguin Productions of Denver, Colorado have produced a 13-week series of half-hour "TV support groups" to air on public television stations beginning in September, 1996. Funding is provided by the Corporation for Public Broadcasting, the Maternal and Child Health Bureau (DHHS), the Carnegie Corporation of New York, the Charles Stewart Mott Foundation, the Surdna Foundation, and the General Mills Foundation. **MELD** of Minneapolis is the Content Director for the Project and will write a facilitators' guide for each program.

Each half-hour **Parenting Works!** program will open with a five-minute "slice of life" video featuring one of the families in the studio audience, who come from diverse ethnic, economic, and cultural backgrounds. These personal documentaries, showing parents dealing with morning and bedtime routines, good nutrition, sibling rivalry, safety, and discipline, will serve as "triggers" for discussion by the parents, facilitated by host Milton Creagh. Creagh will offer viewers tips on the topic of the week, and at the end of the program a toll-free phone number will invite parents to call for more information or referral to a parenting group in their area. Videos, a parent's handbook, and a teacher's guide will be available in Spanish and English.

The idea for the series was developed by Patricia Libbey of Parenting Resources, Inc., whose 30 years of experience in the field of education led her to the conclusion that the process of parents learning from others and sharing their own experiences is crucial to the development of parents and families and contributes to children being ready to learn.

For more information, contact Nina Romontio, Manager, Family Services, KQED, tel: (415) 553-2275.

Revisiting Parenting Groups:
A Psychosocial Approach

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Can parenting groups help troubled families make significant, lasting changes? At the Child Abuse Prevention Project, we asked ourselves this question many times last year. We were reviewing the records of three infants who had died as a result of child abuse. In each case, the baby's parents had not only attended but had completed courses of parenting classes approximately eight sessions long, offering general information on child development and discipline. These classes had not, however, offered a strong supportive component, nor had they evaluated each parent's progress, through pre/post testing.

Parenting groups can accomplish a great deal. They offer information directly related to the day-to-day challenges of caring for young children. They can provide a social support system to reduce isolation. With the capacity to serve many parents at once in a time-limited intervention, parenting groups would seem to be cost-effective. But faced with grim evidence of the limitations of parenting groups to meet the needs of the high-risk families our program serves, we realized that we needed either to modify our model of parenting groups or abandon it altogether. This article describes the Child Abuse Prevention Project's examination of the usefulness of parenting groups with highly stressed families and our efforts to develop, implement, and evaluate an intervention appropriate for this population.

The Child Abuse Prevention Project (CAPP), administered by the Department of Pediatrics, University of Florida, works closely with the State of Florida Department of Health and Rehabilitative Services, the state's child protection agency. As part of a statewide effort, our local office covers a 16-county rural area in North-Central Florida. Together, we have sponsored parenting groups in schools, churches, and public health clinics since 1985. The approach of these groups was primarily educational, offering courses of 6 to 8 sessions each, led by paraprofessional workers and covering topics such as developmental milestones, age-appropriate activities for young children, and discipline. The curricula for different groups were not standardized, and there were no pre/post-test evaluation activities. To undertake a thorough re-examination of the content and approach of these groups, Wayne Wilson, Program Administrator for Children and Families, Department of Health and Rehabilitative Services, formed a task group that included CAPP staff. The task group considered the families to be served, the purpose of our groups, the length of time that would be needed to achieve the purposes desired, curriculum for the groups, and evaluation.

Assessing the needs of individual families

The task group recommended that our parenting groups focus squarely on the relationship between parent and child. In our existing model, parents could enroll in — and complete — a six or eight-session group in which they might talk about behavior management but never be asked about or have the opportunity to bring up other issues of critical importance to them and their children. The old model included no way of evaluating whether parents had changed either their attitudes or practices during their group involvement. We decided that our new model should include a complete, individualized psychosocial assessment for all prospective parenting group members prior to beginning the group. Referrals would be received directly by CAPP from other agencies and/or by self-referral, so that CAPP staff and parents could assess together whether or not the group would be a viable method of helping the family.

This assessment would include a home visit and/or a clinical interview. We would ask parents about their families of origin, including parenting practices. We would ask about parents' sources of social support and their needs as they saw them. We also decided to use the Adult-Adolescent Parenting Inventory (Bavolek, 1984) to assess parents' attitudes and behaviors in four areas of parent-child relationships: 1) age-appropriate expectations of children; 2) capacity to empathize with children; 3) belief in and use of corporal punishment; and 4) appropriate family roles. Following a completion of all assessment materials, a decision would be made together with the family as to the appropriateness of the

referral for a parenting group. For some families, another service, such as ongoing home visiting, might seem more appropriate. This process would allow professional staff and families to link parents with the service most likely to attend to their specific needs.

Timeframe and curriculum

To focus meaningfully on the relationship between parent and child, groups needed more time than the existing six or eight-session model allowed. The task group recommended that each group last 16 weeks. Over a four-month period, we felt, parents could form and establish stronger relationships with the group leader(s) and each other. Relationships among parents would be more likely to last after the group ended and thus be able to reduce families' social isolation in an enduring way. In 16 weeks of group interaction parents would have an opportunity to reveal difficulties in their relationships, as well as to consider and practice viable solutions. This period of practice, along with the support of other parents in the group, would allow parents to select new parenting practices that could be maintained after the group ended — in other words, to internalize changes in attitudes and behavior.

The new emphasis on relationship and psychosocial aspects of parenting would have to be reflected in parenting groups' curriculum. We decided that groups should begin by examining appropriate expectations of children from birth to five. Our interest here was not only to provide information about children's physical, cognitive, social, and emotional development but also to pay special attention to the dependency needs of young children. We had observed that parents who have not been well nurtured themselves or who currently lack social support and/or material resources find it hard to understand or accept the dependence of their infants and young children; dependency may evoke feelings of frustration and anger, and sometimes neglect or abuse.

A second part of examining appropriate expectations would involve helping parents not only to recognize young children's needs intellectually, but also to empathize with their children's inability to cope with these needs without the attention and love of their parents. Part of this process would encompass having the parents review their own individual histories as infants and young children, as a means of developing empathy for themselves and, finally, for their children.

The third part of the curriculum would review developmentally appropriate care and behavior management for young children — the primary content of traditional parenting curricula. We felt that this content should be included, but not until parents had developed a solid understanding of young children's ego development and empathy for themselves and their children. The final portion of the 16-week curriculum would be left open to address issues of concern to each specific group of parents. The parents we serve may be confronting issues of domestic violence, substance abuse and recovery, or marital conflicts. Each group would also allot time for discussion of the group's accomplishments and some attention to the process of loss involved in ending the group.

Evaluation

At the conclusion of a parenting group for families at risk of child abuse, one would like to be able to predict whether or not participants will be able to offer their young children appropriate protection, nurturance, and guidance for the foreseeable future. This simply isn't possible. One can, however, say something about how parents' attitudes have changed during the course of the group and/or whether or not a parent has internalized some of the information and concepts presented. The task group decided that since parenting groups were to run for a period of sixteen weeks, it could be helpful to administer a mid-test after the eighth session, and a post-test after the sixteenth session. The mid-test would be used to ascertain generally whether or not a parent seemed to be grasping the concepts related to appropriate expectations and empathy. Group test results would allow the group leader to adjust the curriculum as needed. The post-test would provide a more complete picture of changes in parenting attitudes relative to four content areas—age-appropriate expectations of children; capacity to empathize with children; belief in and use of corporal punishment; and appropriate family roles.

The task group decided to use a second instrument to provide additional information about parents' progress towards understanding and, particularly, internalizing the concepts presented. In our rural area, families have limited formal education. Their memories of school are not fond ones — "classroom-style" groups are not popular, and written "tests" produce considerable anxiety.

Sample vignettes for a question-and-answer interview for participants in parenting groups

- Your husband likes to swing your three-month-old baby up in the air in his arms. The baby always cries, and your husband gets angry. What would you do?
- Your one-year-old tries to snatch the spoon out of your hand when you are feeding her. Furthermore, she turns her training cup upside down, and the milk trickles to the floor. She insists on doing this although you have told her "no." What do you do?
- Your toddler is frightened by a loud new toy. He runs and hangs on to your leg. What do you do?
- Your 2 1/2-year-old has gone two weeks without wetting his pants during the day. You're in the grocery store, and the child wets his pants. What would you do?

With this in mind, we created a verbal instrument, consisting of ten vignettes or situations concerning children from birth to three and related directly to parenting group content; parents would respond during a question-and-answer interview. (See sidebar p. 20 for examples of vignettes). Although this instrument has not yet been tested for validity, we felt that parent responses to the situations would at the very least give us insight into

Week	Session Title and Target Outcomes
1	**Orientation and Introduction** Parents will gain information about program and gain comfort with group format.
2	**Expectations and Ideals** Parents will learn about their own unrealistic expectations and develop appropriate expectations. Parents will start to develop functional ideas about family life. Parents will start to connect intergenerational family patterns to current problems.
3	**Child Development I** Parents will have an overview of child development and the "tasks of childhood." Parents will learn about sexual development and sexual abuse.
4	**Child Development II** Parents will start to relate developmental stage with child's behavior. Parents will learn baby basics and safety/nutritional issues.
5	**How It Feels To Be a Child** Parents will learn empathy and the importance of a child's perspective. Parents will understand the importance of play. Parents will learn about emotional abuse.
6	**Communication** Parents will learn basics of good communication. Parents will learn about bonding and communicating with babies and toddlers.
7	**Stress and Anger Management I** Parents will learn about stress and anger. Parents will begin to see the connection between anger and violence. Parents will learn about physical abuse.
8	**Stress and Anger Management II** Parents will practice anger control techniques and stress reduction techniques. Parents will learn what are their "triggers."
9	**Mid-Group Assessment** Parents will evaluate what they have learned and set goals for remaining groups. Parent educator will assess progress of group. Some parents may need future assessments by clinical supervisor.
10	**Discipline I** Parents will learn about "discipline instead of punishment" model. Parents will discuss and learn about behavior management. Parents will set goal of one problem to focus on.
11	**Discipline II** Parents will practice discipline techniques through role-play and through talking over practice at home and/or video.
12	**Families with Special Needs** Parents will discuss and gain information about special needs in their families.
13	**Support/Open Group I** Parents will discuss their parenting problems and get support and suggestions. Parents will begin networking with other parents to solve problems.
14	**Support/Open Group II** Parents will gain support from group.
15	**Support/Open Group III** Parents will continue supporting each other. Parents will have a chance to cover needed areas.

Marilyn Nolt

their thought processes and internalization of material. We decided to use the instrument as a pre-test and post-test, to examine differences in response before and after the group experience.

Pilot groups

Once the task group had completed the assessment package, curriculum, and evaluation instruments, we conducted three pilot parenting groups. The first group was conducted in a day treatment facility that was part of a drug rehabilitation program in the local community mental health agency. Participants were all mothers who had extensive histories of drug abuse and multiple attempts at recovery. Their children had experienced multiple placements with relatives or foster families. The second group consisted of parents who had been ordered by the court to participate in parenting education as a result of allegations of child abuse and/or neglect. Participants in this group were typically young couples from one of the rural counties in our area. The third group was conducted at the Florida Correctional Institute, a women's prison in Lowell, Florida. Participants were inmates who were scheduled for release and return to their children, who had been in foster care or with relatives during their mothers' incarceration.

All three groups used the 16-week curriculum developed by the task group, adapted to the population served. For example, in the drug rehabilitation program, issues about drug use and parenting were woven into the content. Since mothers involved in drug use tend to neglect (rather than abuse) their young children, we focused on these issues in all areas of the curriculum. In the group with young rural couples, we did quite a bit of group marriage counseling, with the couples helping each other. During the assessment phase of this group, we learned that these parents' risk of abusing their children was intimately involved with marital disputes, dysfunctional relationship patterns and domestic violence. The use of female and male co-facilitators and the focus on marriage and family life enabled the group to connect the information provided to the issues that were at the core of their particular problems with parenting. The group held at the prison focused on the issues mothers would face during reunification with their children after release — for example, broken attachments between parent and child, difficulties in regaining authority for children from family members who had cared for the children during the mothers' incarceration, and issues of self esteem and re-entry into society.

In keeping with the psychoeducational focus of all groups, role playing, videos, and stories facilitated discussion and helped group members internalize information. These strategies also helped group leaders reach the many participants who were illiterate or had substantial cognitive and/or emotional difficulties. Group leaders consistently highlighted relationship issues. Thus when parents were discussing a parenting problem and possible solutions, they were encouraged to think about how both the child's and parents' responses to a situation were affecting their overall relationship. The parents expressed a surprise at this approach and voiced feelings of frustration with previous parenting classes, where "experts" simply lectured about parenting skills. The difference in approach between the old and new models of parenting groups was well illustrated as we discussed regulation of children's behavior. Most of the participating parents were accustomed to hitting their children for behaviors the

parents didn't like — crying, whining, touching things, hitting, being loud, etc. Many parents who had attended parenting classes, however, had replaced hitting with "time out." The problem was that parents used both hitting and "time out" even for very young toddlers, and without regard for the circumstances in which misbehavior had occurred or an understanding of the child's needs or capacity for tolerating stress. Earlier classes had paid little or no attention to the impact of punishment — corporal or "time out" — on the parent's relationship with the child. In our new model, the groups focused on helping parents to build positive relationships with their children through understanding the children's needs, not merely controlling or modifying behavior.

Participants were able to reflect on relationships with each other and with group leaders. One meeting of the mothers in prison occurred just after release dates had been given out to most of the women in the group. We discussed their feelings getting out of prison. They expressed anger and sadness about leaving the group and had many questions about how the group facilitators felt about them. We were able to help them process their feelings of sadness/loss and happiness/release, and move from a discussion of their feelings to questions about how their children might be feeling about their mothers' coming home. Trying to empathize with their children led mothers to re-examine their plans and expectations about reunification with their children. The discussion led to role plays about how to handle the various ways children might act when they were reunited.

John, Jane, and Tiffany

The experience of John and Jane — a troubled young couple who had participated in five parenting groups — illustrates our new approach.

John (age 20) and Jane (age 18) both grew up in rural Florida. During her childhood, Jane spent several years in foster care after being abused physically and sexually by her parents. John had committed a number of petty crimes.

John and Jane's first child, Brian, was born when Jane was 15 and placed in foster care. A second child, Tiffany, was born three years later. John had battered Jane on numerous occasions and had had restraining orders placed against him by Jane. He currently attends a treatment program for batterers. At the time of referral to our program, John and Jane were under protective services supervision due to allegations of neglect of Tiffany, then three months old. The court had ordered the couple to participate in a parenting group. Jane was also attempting to get Brian out of foster care.

Our psychosocial assessment with John and Jane revealed inappropriate expectations of their young children. They expected Brian to be almost completely self-entertaining, to have the memory capabilities for behavioral rules of a 7-year-old, and to control impulses at the level of a school-age child. They expected Tiffany to cry very little; when she did cry, they saw has being intentionally "demanding" and trying to upset them. John and Jane's emotional immaturity contributed to their inability to nurture and anticipate the needs of their children; their chaotic home life was characterized by violent marital disputes.

John and Jane had attended five previous parent training groups. They remembered learning about milestones of physical development, some information about safety and nutrition, and that they were supposed to use time-out instead of spanking. John and Jane were puzzled about time-out, however — it didn't seem to work with either Brian or Tiffany; the three-month-old and the three-year-old were still being "bad."

As John and Jane's parenting group began to learn about how it feels to be a child, and about the ego development of a young child, these young parents were upset at what we were saying about the needs of babies and young children. They felt angry and resentful of the amount of attention their children were needing and felt unhappy with the child-centered approach we were describing. They knew that hitting was "wrong," but they had no framework for looking at their entire approach to parenting.

Asking about John's and Jane's own childhood experiences provided a solution to the apparent dilemma. Jane said that she couldn't remember her parents taking the time to "walk at her speed" or change their schedules/home environment to accommodate her growing and changing development. John remembered being hit, yelled at, and locked out of the house. He was never allowed to get angry and was expected to comply with his parents wishes and commands. Talking about their own experiences as children led John and Jane to think about what Brian and Tiffany might be experiencing. They started to open up and become willing to find out what a more child-centered approach to parenting would look like.

Role plays proved to be an effective way of offering John and Jane group some working models of a more empathic approach to parenting. For example, John and Jane described problems they were having with feeding Tiffany. They told the group that Tiffany cried and fussed during feeding (problems were exacerbated by the fact that Tiffany has asthma and both parents smoke). John and Jane would feel inadequate, argue about how to deal with feeding, feel even more inadequate when their efforts weren't successful, and then find themselves fighting intensely about a whole range of issues beyond feeding. In a role play, the John and Jane took turns being baby Tiffany, and the co-facilitators played the parents.

Neither parent had ever thought about what Tiffany might be feeling or experiencing in the feeding situation. They knew (from their experiences with protective services and the courts) that they were "bad parents." But when people (like parenting educators) gave them advice, they simply felt more inadequate. John and Jane felt some guilt about smoking, but they were not willing to stop. When they tried to view the problem from the perspective of their baby's feelings and needs, they felt differently. In the weeks following the role play, they reported to the group that instead of getting angry at Tiffany they were focusing more on how to comfort her. This shift in perspective allowed them to solve the caregiving problems around feeding. The group reinforced their new approach. Feeling successful in

one area, John and Jane practiced the new approach in other areas of childrearing and were again successful. Parenting was no longer something that only "good" parents and "the experts" could do.

It would be tempting — but inaccurate — to end the vignette at this point. Totally positive outcomes are rare among the families we serve, and are not to be expected even from our "new model" of parenting groups. Jane and John's parenting successes were interrupted by an episode of serious domestic violence. John left the home, and a restraining order was placed against him. Interestingly, this time Jane was quite clear about her reasons for wanting to live separately from John for awhile. She wanted her home to be free of fighting, for the children's sake as well as her own. By the end of the group's meetings, the protective services worker involved with Jane reported that she was caring for Tiffany more consistently. And in the final group session, Jane announced that she had joined a program to stop smoking.

Lessons learned

The experience of John and Jane illustrates and explains the effectiveness of using a psychosocial approach to designing parenting groups for families who have significant emotional problems. For John and Jane, learning to understanding their baby's need for comfort, through the experience of a role play, represented a clear turning point in their attitudes towards the baby and their ability to address worrisome behavior on the basis of appropriate expectations. This couple had attended and completed five other parenting classes. They had "learned" behavior management techniques, like time-out, but they had never understood why one would expect these strategies to be effective with young children or the circumstances in which they could be usefully applied. Moreover, no one had addressed the most powerful lessons about parenting that were guiding John and Jane's behavior — their own childhood experiences of emotional deprivation. The "new model" parenting group offered John and Jane time and a safe place to revisit their own childhoods, empathize with their own experiences, and then begin to empathize with their baby.

While illustrating the "new model"'s potential for changing parents' attitudes, the experience of John and Jane also reveals the limitations of any type of short-term group intervention. The parenting group did what it was designed to do, creating an opportunity for significant changes in attitudes and for experiencing success as attitudes were translated into more appropriate caregiving practices. The group alone could not resolve the couple's overall marital difficulties nor prevent the recurrence of domestic violence that split the family apart once more. Since John and Jane had been ordered by the court to participate in a parenting group, we reviewed with their protective services worker the results of pre- and post-tests and to discussed to both progress made and concerns still to be addressed. Along with protective supervision, we recommended continued mental health counseling for both parents and home visiting for Jane after the end of the parenting group.

Our work with all three pilot parenting groups suggests strongly to us that our new model works much more effectively than the old in helping parents to both improve their parenting skills and internalize a new perspective for viewing their children and their children's needs at any age. Individualized assessments, a longer-term group that emphasizes process, and a strong evaluation component all combine to strengthen the support we offer to an "at risk" population. As we conduct various groups using this model, we will evaluate the need for additional changes. We have already learned, for example, that we need to address parents' concrete needs for transportation and child care, and we are considering adding a therapeutic component to the child care provided for children over three. The process of "revisitation" will continue as we gain experience with our psychosocial approach to parenting groups.

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Family Support While You Wait:
Lessons from the Detroit Family Project

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Low-income urban parents with young children spend many hours in health clinic waiting rooms. Although many of these families share the same characteristics and concerns as families who participate in family support/parenting education programs, relatively few of parents who use clinics seek out family support or parenting education services. Some may be unaware that such programs exist; some think that they are only for "bad" parents who neglect or abuse their children; some fear being made to feel "stupid" in parenting classes; some lack transportation; some have lifestyles that are not congruent with regular attendance at a parenting program.

In a pilot project of the Detroit Health Department, we tested the possibility of touching the lives of families with young children through casual but meaningful interactions between parents and parent educators where the families are — in clinic waiting rooms. The model has involved forging new collaborations between the health department and two community partners, Wayne State University's Detroit Family Project and the Skillman Foundation. An important aspect of developing this program has been ongoing evaluation, using a "continual learning" model of data collection, analysis, feedback, program modification, and further data collection. This article gives the rationale for the project, describes the service delivery model as it stood at the end of the project, provides information on program effectiveness, and presents the accumulated wisdom of the project in a discussion of "lessons learned," including how the program was modified over time as a result of the "continual learning evaluation." (Gray, 1993)

Rationale

As hard times and social change have taken a toll on American families, the value of offering young parents and parents-to-be support and information to help them raise their children successfully has become well understood. Across this country, an extraordinary variety of programs has evolved which combine some form of parenting education with family support. These programs commonly emphasize family empowerment and a focus on helping parents so that they can become more effective parents of their children. Professionals serve as resources rather than as prescribers of what families need. These imaginative, adaptable, user-friendly efforts have captured national attention as mainstream institutions seek to learn how to broaden their responses to resistant social problems associated with family failure (Weiss and Halpern, 1990; Bruner and Carter, 1991; Allen, Brown, & Finlay, 1992; Weissbourd, 1994; Kagan and Weissbourd, 1994; Downs, Costin, & McFadden, 1996.) As Schorr (1991) has pointed out, a current challenge is to incorporate family support programs into large service systems, without sacrificing the flexibility and responsiveness which make these programs effective.

During the 1980s, planners at the Detroit Health Department's Bureau of Substance Abuse, aware that certain characteristics of family life were among the risk factors in the causal chain leading to substance abuse, promoted the development of family support/parenting education programs as an affordable strategy for reaching large numbers of parents. The Bureau contracted with Wayne State University's Urban Families Program, an organization that had successfully developed family support programs in various settings throughout the city, to design and implement a program that would realize this initial vision. This effort became the Detroit Family Project.

The families

Health department waiting rooms were chosen as the site for the program because parents and children congregate there, often experiencing long waits for their clinic appointments. The waiting room families are typically young single mothers between the ages of 18 and 30, with one or two preschool age children, or pregnant with a first child. Seventy percent of the families have only one parental adult in the home; 75 percent of the mothers are unemployed. Over half have incomes

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under $10,000. About 80 percent of the mothers are African American, 12 percent are Latino, and the rest are white, Arabic, Asian, or other (Mavis et al., 1993; Nahan et al., 1991). Besides young single mothers, grandparents raising grandchildren, pregnant and parenting teenagers, and fathers are also in waiting rooms.

Many families who use clinic services do not use other social, educational, and supportive services, although their children may be at risk of abuse and neglect, developmental problems, and school failure. Surveys of persons using the health clinics verify that most are unlikely to use family support or other preventive social services, even though their family characteristics, as measured by various standardized instruments, indicates that they share the same problems as people who do make use of such services (Mavis et al., 1993), such as low incomes, high unemployment, and low rates of high school completion. Their information on parenting and family life comes mainly from their own families; to a lesser extent, they report getting information from friends, TV shows, printed media, and other parenting classes (Downs, Walker et al., 1995). Thus, the waiting rooms are places to meet with families who are not familiar with family life education/ family support programs and who are not involved in other service systems.

As observed above, parents have told program staff that they have not sought out other family support/parenting education services because they don't think they need or could benefit from these programs and have described a number of other barriers to participation. The waiting room approach overcomes these barriers by scheduling the introduction of parenting information and family support into the flow of their lives, in a way that allows them to choose whether to take part. The approach works on the premise that adapting parent education to parents' schedules — in this case, time in the waiting rooms — will demonstrate that parent education/family support is, indeed, an experience from which all families can benefit.

Program objectives and design

The overall goal of the waiting room approach is to enhance the ability of local families who use the health department to provide a nurturing environment for their children that supports their optimal development. Within that goal, the project has three related objectives:

- to respond to the immediate needs of families for parenting guidance and support;
- to increase awareness of parenting concepts and child development information; and
- to increase utilization of other support services available to families at the health centers and elsewhere.

The program staff, called parent facilitators (PFs), rotate among waiting rooms of the clinics where families gather (mainly obstetrics/gynecology and pediatrics) and WIC (Women, Infant, and Children) food coupon distribution centers. Within a basic structure, the parent facilitators must use creativity and innovation to meet program objectives while adapting to the flow of the clinic around them and the distractions which deflect attention away from their presentations.

The "listening" curriculum

Creating a curriculum (Walker, 1993) to address the specific needs of Detroit's families for information and support in raising their children involved Urban Families Program staff and more than 60 community leaders and residents on the project's advisory board. In extensive meetings, staff and advisors identified six topics for the curriculum: choices and consequences, substance abuse, school success, employability, sexual responsibility, and conflict resolution.

The curriculum was developed through continual interaction between the parent facilitators, who experimented with content and format, and the curriculum development specialist. The unstructured and distracting environments of the clinic waiting rooms, in which groups ebb and flow, required an approach that would more immediately engage participation than traditional didactic presentation of material. The result is a "listening" curriculum, in which parent facilitators introduce parenting concepts and then elicit responses by drawing parents into discussions with questions about their own experiences and attitudes.

The curriculum guides parent educators in capturing the interest of parents in nontraditional settings. It invites parents to share their views and concerns about a specific topic, exploring a range of perspectives rather than prescribing "correct" behavior and values. Presentations stress short parenting messages, discussion of the experiences of group members, interactive activities (including role-plays and brainstorming), and handouts that reinforce a session's major themes. One-page session plans for each session contain a simple statement of a major theme and three parenting messages.

Based on the questions and concerns of parents over the course of the project, a second volume of the curriculum (Walker et al., 1996) has been developed to reflect topics beyond the original six on which parents repeatedly seek information: pregnancy and infancy; five to seven year-olds; eight to twelve year-olds; self-esteem; money management; adult relationships; and grief and loss.

In addressing the important area of managing children's behavior and teaching them right from wrong, parent facilitators seek to expand the parents' repertoire of responses to behavior that parents find problematic. Small insights into the influence of one's family of origin and into the consequences of various behavior management techniques are all that it is possible to expect in the informal, brief format of the waiting room sessions.

David Kessler/Photo Agora

As one parent facilitator described her efforts:

The basic thing they have learned about child rearing from their own families is discipline. They say you have to whip the kids, that they were whipped when they were children. I tell them that we can change that. "Perhaps you've said, 'When I have kids I'm not going to do that.' Well, there are other ways to teach and raise kids." (Genus, personal communication)

Through group discussion, parents are able to reflect on the way that they were raised and to talk about things they would like to do differently. One mother observed:

I always have to stop and think about what I learned. (The parent facilitator) gave us a printout on verbal abuse. I never looked at it from that perspective. I keep it on the refrigerator. I go back to it. I'm a little more kinder and patient. I have my three sons. My oldest is a leader. The middle one is a crybaby. He used to make my skin boil. I'd say, "You're a brat." That's verbal abuse. My mother does it. I don't want to do it. Now I say, "It's okay. You don't need to cry." I don't blow up as quickly as I would. I don't compare them as I used to. I'm conscious now of their different personalities (Nahan, Williams, & Merithew, 1992).

The approach

Clinic waiting rooms are far from ideal environments for teaching and learning. Typically they are noisy, dreary, crowded spaces. There are no toys or reading matter — only a television, tuned inevitably to a soap opera or talk show. Waits are lengthy; the mood is, at best, stoic. Children fidget, cry, or mope listlessly. Parents often become irritable. Few parents bring toys or snacks to help their children occupy the time. Some parents react with impatience, verbal abuse, and physical punishment to their children's fidgeting and unhappiness.

Into these waiting rooms the parent facilitator (PF) wheels a small cart, containing snacks, handouts and brochures, books and toys for children, and a small flip-chart. The carts are an efficient way to transport parenting materials around the large, crowded centers; with their colorful signs, they have the additional advantage of making the parenting program visible. The staff have come to be known as "the juice ladies (or juice men) with the cart." Once in a waiting room, the PF stops to chat informally with small groups of parents and children, offers juice and crackers, and, after forming an initial relationship, will either discuss parenting concepts within the framework of a problem which a parent presents or will launch into an informal presentation of simple parenting messages. Brief messages from the curriculum are written on a small flip chart mounted on the cart, which provide a starting point for discussion with parents.

Parents define their level of participation. Some choose not to become engaged, but they may learn something from the PF anyway, as the following example illustrates:

This man was up there talking and I thought, "Why doesn't

he just shut up, no one wants to listen to him." Then I saw him explaining how to put on a condom and to squeeze the air out of the tip. I thought, "Oh, that's how I got pregnant with Jamal; we didn't squeeze the air out of the tip!" (Williams, 1992).

The staff are friendly, courteous, and respectful to families. They take an "empowerment approach," emphasizing that parenting children is a major responsibility that parents wish to do well, and that all parents need help from time to time in learning new ways of helping their children to grow and develop. Some parents respond to the offer of friendly interaction and help:

I was awaiting for my appointment when I was approached with flyers and information. I wanted to learn about how to care for my child. I am pretty lonely in this country. Most of my immediate family is far away and the program serves to answer a lot of my questions (Nahan, Williams, & Merithew, 1992).

Another mother emphasized the social aspects of the program:

Because when they come, before everybody just be sittin', they come in and we have somethin' to talk about. Everyone sittin' not talkin', we introduce ourselves. And now we talk when they're not there. We know each other (Nahan, Williams, & Merrithew, 1992).

A basic tenet of the program is that as parents are nurtured, they become empowered to nurture their children. A parent facilitator describes her approach to a stressed parent, expressing concern for the parent, rather than confronting her directly about her behavior with her children:

I saw a woman slam her two children, ages about two and three, into chairs in the waiting room. I approached the mother and said: "Did you not get a good night's sleep last night?" The mother indicated that she had slept well. I then said: "I saw you treating your children impatiently and I thought you must be very tired." The woman then told me about her frustration with the children's father, who was supposed to provide transportation to the health center, but now had told her that she and the children must take the bus home. This 32-year-old mother had two older children at home, and was feeling overwhelmed and under-supported. I invited her to talk with me in my office, and she shared with me her frustration about the children's father. I was able to provide support, suggest the Baby Van for transportation, and help the mother see that when she was frustrated with the baby's father she should not take it out on the kids (Walton, 1995).

Related project services

The waiting room approach is part of a larger demonstration project for families at the health department. As a result of initial efforts in the waiting rooms, which revealed a large, unmet need for accessible, voluntary family support services, the Skillman Foundation provided five years of funding for scheduled parenting education workshops and individual supportive counseling at the health centers, as well as a paraprofessional home-visiting program, vans for transportation, and substance abuse assessment and referral services. Within this array of services, the waiting room sessions are a point of entry. Parent facilitators routinely offer information about all health department services, make personal referrals, and maintain communication with staff of the related service programs. For example, one pregnant mother described a conversation with the PF:

I ask questions (about prenatal care), like, "Do you have a doctor when you get to six months?" (The PF) explained it to me. At first I was upset. No doctor. Then she explained that mid-wife was the same as a doctor, and at the hospital, the doctor (will be there to deliver the baby) (Nahan, Williams, & Merithew, 1992).

The parent facilitators also make referrals to other community services, such as employment, housing, educational, and emergency services. In addition, they help parents ask appropriate questions of health staff and teach them how to make more effective use of health services.

Once parents have begun to trust the facilitator and believe (s)he can help them, they are likely to see her/him as a comfortable, accessible source of information on a wide variety of topics. As one parent facilitator explained:

Mothers come up to me and say, "I'm going to be evicted. They are going to put me out. What do I do?" Or they say, "I want to establish paternity. Where do I go?" "I'm thinking of going back to school. How do I get started?" (Genus, 1995)

Staffing and training

The project has five full-time parent facilitator positions to serve six health centers and three community service centers. All parent facilitators are African American. Both women and men can be effective parent facilitators. All parent facilitators have bachelor's degrees; two have master's degrees as well. The staff have backgrounds in the human services, including human development, nursing, social work, and early childhood education, and have had extensive experience in working with parents.

In addition to experience and background, the project has identified qualities which help parent facilitators be successful in the waiting room format, including:

- excellent communication and listening skills;
- empathy;
- good group presentation skills;
- the ability to work autonomously in a host setting;
- the ability to relate to large organizational structures;
- flexibility and adaptability; and

• a tolerant, non-judgmental approach to families.

Given the autonomy of the field staff at the centers and the lack of uniformity in their working environments, the program recognized that a strong training program to establish commonalties and program cohesiveness would be essential, particularly in the early years. Staff spend one to four days a month in group training and supervision. These sessions are a forum for learning new information and skills, sharing experiences, problem-solving, providing mutual support, and promoting program identity. In addition to group training, each staff member receives individual supervision, including in-field observation every month. These highly trained staff are now in demand to provide presentations to parent groups around the city, in schools, churches, community-based organizations, and other forums where parents gather.

Evidence of program effectiveness

From the beginning, the waiting room approach has received annual process evaluations, both internal and external. Other sources of information on the project are program data, a survey of waiting room participants, and group and individual interviews with project staff.

Attendance and sessions

The five parent facilitators conduct a total of about 2,000 sessions in the clinic waiting rooms each year. During these sessions, they collect about 25,000 signatures on their "guest lists" annually. These large numbers of contacts reflect the program model, which is intended to reach large numbers of persons in a low-intensity, "brief encounter" format. On average, parents at any given session have attended two or three previous sessions. About a quarter of those attending a session are likely to be first-time participants, indicating that even after five years of operation, the project still touches many families new to the waiting room approach.

Parents' views

Internal and independent surveys of waiting room participants (Mavis et al., 1993) reveal that parents are uniformly very satisfied with the format of the waiting room approach. Families report that what they like best is a chance to be heard and to learn something. Typical comments include: "I am a better parent now"; "I think more about my actions and words"; "I've learned to be more patient with my kids and to enjoy them more."

Views of health clinic administrators and staff

The Detroit Family Project's initial task — integrating an autonomous program, with external staff, into a highly structured host setting — raised a welter of logistical and administrative complexities that required considerable negotiation of boundary issues and formal relationships among staff at all levels. The project service model,

Robert Maust

with its emphasis on voluntary participation and definition by participants of the services to be utilized and the level of participation, differs significantly from the traditional client/service provider or patient/professional model of health systems. The traditional medical model assumes that a problem be identified and a treatment administered. In contrast, the family support model emphasizes empowerment, with the family identifying the needs, and setting its own goals.

This "clash of cultures," as it was described by one health department administrator, was addressed in many meetings involving administrators and staff at all levels of both the university-based Urban Families Program and the health department. Meeting participants negotiated roles and boundary issues, clarified expectations for a team approach, and learned about each other's values concerning serving families, as well as about the constraints and difficulties under which each group worked.

During the first three years of the project, outside evaluators conducted interviews periodically with health department administrators and staff to obtain their perspectives on the waiting room approach and other components of the services funded by the Skillman Foundation (Nahan & Williams, 1993; Massie, 1995). Overall, the evaluators found that the administra-

tors assessed the project very positively. Highlights of their findings were:

- The majority of the clinic staff interviewed noted that the—program is valuable to clients. One respondent said, "The parenting program adds a bright spot to the clinic. They bring a completeness to health care. Health care is more than just being seen by the doctors, nurses, and dentists." Another respondent said, "Parents seem to enjoy it. They call and come again. It keeps the patients occupied."
- The program is viewed as an integrated component of clinic services by the clinic staff interviewed.
- One of the unintended outcomes of the program has been to make clinic staff aware of the importance of appropriate parenting skills. One respondent stated: "They have made me more aware. (The Parent Facilitator) did a poster about the rules that parents should live by, so around the clinic you can always find something about parenting." Another staff member said, "I listen a lot even though I don't have time to sit, but I still try to hear."
- The clinic staff interviewed believe that the program helps the clinic clients. Comments included, "When they see parents yanking or spanking the children, they ask the mother to come and speak to them." "When the program staff see inappropriate behavior, they give the parent a flier and introduce themselves." (Massie, 1994)

Recruiting families into structured programs

Along with providing information on parenting to persons who might not receive it from other sources, the waiting room approach also has the goal of recruiting parents to utilize other services at the health department, particularly the regularly scheduled parenting classes and the individualized supportive counseling sessions offered in the health centers. The potential of the waiting room model to recruit families into more high-intensity approaches is somewhat complicated to assess. On the one hand, the large numbers of people in the waiting rooms are easily accessible to recruiters. Parent Facilitators encounter thousands of people each year and can encourage them to participate in parenting classes and supportive counseling. Recruitment through waiting room contact is, in fact, successful: about two-thirds of participants in the serial workshops and supportive counseling sessions at health centers during the past year were recruited through contact in the waiting rooms. The other 33 percent came to these programs mainly through referrals from health clinic staff or community agencies, or through word-of-mouth (friends or relatives).

On the other hand, it is important to recognize that most families in the waiting rooms do not move on to attend the scheduled workshops or supportive counseling. The waiting room surveys indicate that these parents are satisfied with the help they are getting in the waiting rooms from the parent facilitators and do not wish to attend other programs. The experience of the project has shown that the waiting room approach is a key source of information and support for parents in and of itself, apart from its role in recruiting parents to other, more high-intensity approaches.

Lessons learned

After five years of operation and of evaluations that have provided information to guide program modification, the project has learned a number of lessons about operating parent education/family support programs in health center waiting rooms.

1. Clear program objectives and key parenting messages must be combined with great flexibility in approach. This program model needed to steer a middle course between two hazards: 1) following a rigid curriculum in a standard format regardless of circumstances and 2) providing no structure to staff, thus encouraging the dangerous assumption that staff are supposed to respond to any and all needs of families. The middle road, which minimizes both risks, emphasizes clear objectives and flexible implementation.

Clear program objectives, communicated to both project and host-setting staff, reduce confusion about what the project staff are trying to accomplish and give credibility to the program. Clear objectives help the project staff remain "on task" and "on message" as they work autonomously in widely variable settings. At the same time, staff need to be allowed a great deal of flexibility in how they accomplish their objectives. Parent facilitators' first task is to engage parents, and they must find ways to do so in the midst of the ebb and flow of waiting rooms that vary widely from center to center. Parent facilitators must then be able to involve parents from many different backgrounds in constructive, non-threatening conversations about their problems and concerns in raising children and managing family life. Parent facilitators work best when they are free to use the techniques they are most comfortable with. For example, in order to get parents' attention and encourage them to participate, some staff engage parents in simple craft projects as a way of nurturing them and involving them in parenting discussions in a natural, non-threatening way. Others use videotapes or engage parents in a discussion of current events as a way of reinforcing parenting messages.

2. Small-group and individual interactions work better than large-group formats. In the beginning of the project, the parent facilitators covered the curriculum by addressing the entire waiting room, using a flip chart to focus attention on the day's topic. The results of a process evaluation, reinforced by observations of supervisors and staff, indicated that the large-group method was not successful in engaging all or most parents, and was confusing in a setting where people were con-

stantly coming and going for appointments (Dannis, 1994). Therefore, the approach was modified so that parent facilitators worked with their materials in a small cart and used their time in the waiting room to talk with small groups of parents. This approach is more comfortable for the staff and has resulted in more spontaneous questions and participation from parents. It allowed the Parent Facilitators to adapt to parents, not the other way around.

3. A second staff person to engage the children while parents are talking with the parent facilitator is an extremely useful program enhancement. During one year of the project, it was possible to deploy to each clinic two-person staff teams made up of a professional parent facilitator and a paraprofessional child care worker. The child care worker engaged children with books, games, and toys, while the parent facilitator talked with the parents. This format frees up parents to focus on a discussion with other adults and provides opportunities to model non-coercive child management techniques. Paraprofessionals who are members of the community from which the parents come may be able to communicate easily and effectively with parents.

4. The program works well with various ethnic groups. Detroit's health clinics serve African-American, Latino, Arab/Chaldean, and white families. Some modifications in approach are needed for different cultural groups. Obviously, all parents need a facilitator who speaks their language. Latino and Arab/Chaldean mothers seem comfortable discussing family issues with female parent facilitators, while African-American mothers engage comfortably in discussions with both male and female facilitators. Group norms vary as to appropriate contexts for discussing sexual issues. All parents need a facilitator who understands the realities of their lives, is sensitive to their cultural values, and knows the resources available to help families in their communities.

5. The success of the project depends, to a great extent, on the personal characteristics of the staff. As noted above, the qualities that enabled parent facilitators to engage parents in this demanding model included excellent communication and listening skills, empathy, good group presentation skills, the ability to work autonomously, the ability to relate to large organizations, flexibility and adaptability, and a tolerant, nonjudgmental approach to families. These specific qualities were identified over time, partly as supervisors designed and modified "Observation Checklists" used to rate staff abilities. For example, the "Interaction" section of the checklist asks supervisors to note whether the parent facilitator comments on appropriate parent/child interaction and uses it as teachable moments for the group; engages children appropriately; involves parents appropriately by soliciting feedback, refraining from arguments, using probing questions, and keeping the session interactive; and models appropriate behavior and interactions. Staff are a key resource and must be supported by knowledgeable supervision and ongoing training.

6. Adult learning styles should be respected. When parents were asked what they liked about the waiting room sessions, they almost always said that they valued the opportunity to share experiences and discuss ideas with the parent facilitator and other parents. Receiving information was important, but they preferred to have the information included in informal discussion rather than formal presentations. Topics such as the importance of teaching children about drugs or alternatives to spanking elicit more discussion and parent involvement than the presentation of technical information, such as how the HIV virus works on the immune system, or even the ages and stages of child development. Information on these latter topics can be distributed through handouts in question-and-answer or chart formats.

7. The waiting room approach can reach large numbers of parents who are not receiving parenting education or family support elsewhere. This program model provides parents with: 1) a helpful response to immediate needs and 2) referrals to more sustained parent education and family support programs and other services. The project demonstrated that it is possible to touch the lives of very large numbers of parents (about 25,000 a year) through brief encounters in the waiting rooms. Most of these parents were not getting parenting education or family support services from other sources outside the family. This is a major strength of the waiting room approach, and sets it apart from the majority of parent education and family support programs, which require parents to come to them.

8. The support of the host setting is crucial to the ongoing success of the program model. The meeting of "two cultures" — one a "family-friendly" program featuring responsiveness, flexibility, worker autonomy, and creativity and the other a large medical bureaucracy — raised issues that required ongoing negotiation. These issues included: the role of staff in providing informal counseling on request to staff in the health centers; accountability of project staff to health center administrators; mutual expectations and clarification of roles in cross-referring families; and space for storing project materials and for carts, flip charts, posters, and other materials in the waiting rooms.

Unanticipated but important benefits accrued in running a family support program in the health centers. The project has made a difference in the institutional climate of those centers. Project and health center staff have begun to work together in teams to help particularly challenging families. The health center staff have begun to take a softer, more helpful approach in dealing with the families. Many skeptical staff who initially saw the program as an imposition or as a possible threat to

their way of doing things now believe that the program is a valuable aspect of the health center's services. This is a sustainable project outcome that will continue to benefit families after the project has ended.

9. The waiting room approach can be transferred successfully to other settings. Because of the waiting room approach's success in reaching families who have not had exposure to formal parenting information from other sources, the model has been replicated successfully in other settings, including public assistance office waiting rooms, a mobile health clinic that offers well-baby services in community-based organizations, homeless shelters, and a midnight basketball program for men.

Conclusion

Offering parenting information in the waiting rooms of large urban health centers is not a panacea for the multiple problems and stresses that families face in urban environments. However, such a program can introduce parents to new perspectives for raising their children and can provide valuable support, guidance, and practical help to parents who are struggling to raise children in difficult and often isolated circumstances.

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Rose Schaffer, and
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Beach Center on Families and Disability, The University of Kansas, Lawrence, Kansas

Rachael and Sarah are the daughters of Van and Rose Schaffer of Lawrence, Kansas. Rachael, three years old, is an outgoing young lady whose eyes twinkle with enthusiasm and self-assurance. Sarah, at 18 months, is a "ham" for any audience. She enjoys musical toys and playing with Rachael or any of the nearly 40 cousins she and Rachael share.

Almost from the day she was born and the initial diagnosis of Down syndrome was made by her family's doctor, Sarah's parents began putting together a network of service providers for her. The Schaffers had a vision from the beginning of Sarah's being a part of the family, the neighborhood, and the community. Van concluded, "We want Sarah to have an equal chance at life — for her to have a shot at all the things others have a shot at. We don't want her to have to live within some set of boundaries just because she has Down syndrome".

The network the Schaffers put together provided very fine services, and Sarah was doing well in the developmental areas those services addressed. The initial challenge, however, was pulling that team together to make sure that "the right hand knew what the left hand was doing."

Group Action Planning is a "hybrid" family support model which includes some of the characteristics of both individualized team planning and support groups. Action Groups are very similar to what an ideal IFSP (Individualized Family Service Plan) approach would be; however, they differ significantly from the reality of most IFSP processes (Able-Boone, 1993; Minke, 1991; Turbiville, Turnbull, Garland, & Lee, 1996).

Group Action Planning occurs when family members, friends, and service providers form a reliable alliance with each other for the purpose of creating a synergistic community (Katz, 1984). What do we mean by a synergistic community? A synergistic community is one in which all participants generate increased activity and energy (Craig & Craig, 1974) so that the "whole is greater than the sum of the parts." In such a context, each person's efforts significantly and exponentially advance individual and group goals, as well as enhancing each participant's motivation and knowledge/skills (Turnbull & Turnbull, in press). Synergistic communities create a different vision about what life can be when one has a disability — a vision characterized by inclusion, contribution, interdependence, and empowerment. The two fundamental characteristics of Action Groups are that they (a) create a context for relationships and interdependent caring and (b) through the relationships and caring, engage in creative problem-solving, enabling participants to get what they want and need (i.e., experience empowerment).

Typically, early intervention tends to be aimed more at child and family change as contrasted to changes in ecological contexts (defined by Bronfenbrenner [1979] as the immediate environment in which the family lives [microsystem], the interaction between those immediate environments [mesosystem], and the larger milieu in which these various environments are embedded [exosystem and macrosystem]. Group Action Planning recognizes that forming "ecological partnerships" across all levels of the child and family's environments will enhance the responsiveness of their ecological contexts. The idea is to build a network of people across all ecological levels who are passionately committed to the child and family. These people include nuclear and extended family, friends, community members, early childhood service providers, and generic community service providers (e.g., Brownie leaders, church school staff, YMCA staff).

The network is brought together to support the child and family in "getting a shot at life." Especially within the field of disability, there has been such an emphasis on professional support from the earliest days and weeks of a child's life that potential support from significant others, including family, friends, and community members, is often overlooked. Although service providers offer necessary and helpful support, they make up only a small aspect of any child or family's full ecology. The more that comprehensive ecological linkages are made from the outset and evolve over time, the more likely it is that the child will "get a shot at life."

With their diverse expertise and membership, Action Groups often change the role of service providers relative to a family. Unlike many traditional relationships in which professionals have "power-over" families through authoritative control, an ecologically based reliable alliance is characterized as having "power-with"

others. In such an alliance, respectful, non-judgmental, and ever-available support is shared in relationships that are sustaining for a long period of time. Reliable alliances, characterized by "power-with" relationships, foster collaboration in which all parties are willing, and even eager, to learn from their shared experiences and diverse expertise. Furthermore, "power-with" relationships can lead to "power-from-within," which "...gives a person courage to act when important values are threatened, even if the short-term prospects for success are poor" (Zipperlen & O'Brien, 1993, p. 24).

We will focus on five key components of Group Action Planning:

(a) inviting support,

(b) creating connections,

(c) envisioning great expectations,

(d) solving problems, and

(e) celebrating progress.

Action Groups have been used much more frequently with elementary/secondary students and adults (as contrasted to infants and toddlers) both in the literature and in our own experience (Falvey, Forrest, Pearpoint & Rosenberg 1994; O'Brien & Lovett, 1992; Stineman, Morningstar, Bishop, & Turnbull, 1993; Turnbull & Turnbull, 1996). Although we have conducted many Action Groups with older students and families, we are in the preliminary phase of Action Groups with families with infants or toddlers, such as the Schaffer family (just three "gatherings" so far). Throughout the paper, we will illustrate the components of Action Groups by highlighting the Schaffers' experiences and predicting the evolutionary composition and focus of their Action Group in the coming years.

Inviting support

Unfortunately, many families of children with disabilities have smaller social support networks than other families. Indeed, they sometimes get their only support from nuclear and extended family members (Herman & Thompson, 1995; Kazak & Marvin, 1984). Even nuclear and extended family support is often difficult. In a quantitative study of 17 families, all of whom had a child with a disability coupled with problem behavior, most parents described many nuclear family challenges. Sibling relationships characterized by feelings of resentment, embarrassment, and frustration were particularly difficult. Approximately half of the families commented on the difficulty of establishing comfortable and connected relationships with grandparents, aunts, uncles, and cousins (Turnbull & Ruef, in press).

In addition to difficulty with family relationships, over two-thirds of the families reported that their children, whose ages ranged from 4 to 35, lacked even a single friendship. Clearly, forming relationships with significant others, even within the microsystem, is a major

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challenge for many families whose children have a disability.

Typically, families with a child with a disability feel most comfortable in inviting members of the mesosystem — primarily professionals who work with the child— to be charter Action Group members. Many families find it easier to rely on professionals than to foster emotionally connected relationships between the child and members of the nuclear and extended family, neighbors with whom they live in close proximity, or community members who can be instrumental in accessing inclusive settings and opportunities.

When she's a little older, we might invite one or two of her friends—her buddies—who would be in school or activities with her. For now, we want those most involved in her education or caregiving to come.—Van Schaffer

As Action Groups begin to address significant barriers to the actualization of visions (e.g., locating an inclusive preschool, attending the children's program at one's church or synagogue, taking classes at the local YMCA), community members who can help ensure that these opportunities are available and who represent membership in the exo-, meso-, and macrosystems can be invited to participate.

Parents often need support as they prepare to issue invitations to participate in an Action Group; many families of children with disabilities feel that they should not "impose" their "problems" on others. A professional might offer to serve as the facilitator of the Action Group and to support the parents in inviting others to

participate or in issuing invitations themselves. Specific steps that might be taken in inviting support include:

- Identifying a facilitator who has keen skills related to emotionally-connected communication and systematic, creative problem solving;
- Given the priority issues that need to be addressed, determining who can help with those particular problems and issuing invitations to these people for Action Group participation;
- Supporting families in knowing how to reach out for assistance by devising and practicing "invitational scripts" and even role-playing extending invitations, to encourage family members to be comfortable with seeking support;
- Encouraging families to recognize that there are reciprocal benefits for people who participate in Action Groups — the family will not be obligated or "in debt" to them;
- Connecting families with veteran families who have invited support successfully so they can share what has worked for them.

Identifying the service providers for the gathering was fairly easy. They had been working with Sarah and her family for some time. Everyone was personally invited to come to the gathering. These invitations were followed by a hand-written invitation.

Sarah's "gathering", as we've come to refer to our Action Group, has 10-15 people. It is somewhat enlarged because, since some of her providers are graduate students in speech-language pathology at The University of Kansas, meetings include their supervisor (Jane) as well as the students (Matt and Andria). Three members of the daycare program attend including the director (Shelly), Sarah's current teacher (Tracy), and her next teacher (Lance) from the toddler room. Her occupational therapist (Kay), early childhood educator (Dena), and Parents as Teachers educator (Gayle) also attend. In addition to the service providers, Sarah's gathering includes her aunt (Mary, Rose's sister) and the mother of another child who has a disability (Ann). The family service coordinators (Kay C. and Vicki) facilitate the gathering, including inviting many of the members.

Rose is thinking that a nurse practitioner from their pediatrician's office should be invited to attend. "She could keep the doctor better informed of what is happening for Sarah and also give him an idea of what he could suggest for other families. He has told a number of families about using sign language with their children because of Sarah's success with it. This would be something else he could let them know about."

For Sarah's family, inviting support involved surmounting several barriers. The first was time — many of these people have irregular schedules, and time "playing phone tag" was substantial. Van described another barrier: "I don't know how you get this group to come together. If we tried to do this alone without Vicki and Kay's assistance, encouragement, and positive thinking, I don't think anyone would have come." In fact, people are excited about coming and are committed to Sarah and the vision for her life. Families deserve affirmation in knowing they are not "burdening others."

To accommodate everyone, recognizing that all members also have families, Sarah's gatherings begin at 5:15 p.m. This timing means that many participants are asked to extend their working day rather than give up an evening. Some participants can adjust their hours and go to work later on the day of a gathering; others are "giving" their time as a part of their commitment to Sarah and her family.

Part H funds have also been approved for paying for the time of some members who are participating under the "family training" early intervention service category. Gayle (Parents as Teachers educator) comments, "We should prepare more people to do IFSPs like this one—a gathering. I've been to too many where people sit on opposite sides of the table, depending whether you are the parents or providers. Sometimes it's difficult for me to decide on which side of the table I belong!"

Creating connections

Inviting people into the group accomplishes the prerequisite task of physical presence; however, forming the bonds of a reliable alliance among those people is a key to establishing a synergistic community. Creating connections is consistent with Maslow's theory of human motivation, which underscores the need to experience belonging as a prerequisite to meeting needs, such as self-esteem and self-actualization, at higher levels (Maslow, 1970).

A key component of creating connections is strengthening the emotional and social connections between and among group members and the child and family. When children have severe disabilities and require augmentative communication, it is especially important for others to know how to get on the child's "wavelength." A natural learning opportunity is provided when the child who is the focus of planning is present at the Action Group meetings and has a chance to interact with the participants. Some strategies to accomplish connections with the child include:

- Modeling and sharing by people who already have emotionally connected relationships with the child, so that others learn how to make a special connection;
- Reflecting on the child's cues for expressing preferences, pleasure, and displeasure and responding to those cues;
- Sharing stories about the positive way that the child and family contribute to others in the group;
- Reflecting on difficult experiences in connecting with the child and engaging in creative problem solving to overcome those difficulties.

In contrast to the somber ambience of many individualized team meetings and parent support groups, Action Groups particularly seek to infuse social frivolity and just plain fun into relationships. Some strategies for

accomplishing connections among participants include:

- Holding meetings in comfortable settings such as the family's home or a favorite neighborhood location;
- Serving food and allowing time for comfortable visiting;
- Celebrating all group members' birthdays, holidays, and special occasions;
- Infusing humor, laughter, and warmth into the ongoing conversations and problem-solving sessions; and
- Making personal disclosures of feelings related to issues being discussed, as well as concentrating on "facts."

Sarah always is present at the gatherings. One of the first things done at the first gathering was to have everyone talk about the things they really enjoy about Sarah. Some of the qualities people mentioned were her sense of humor, her persistence, and her self-confidence.

Sarah's communication currently includes the use of signing. Her big smile and her kisses, however, communicate with everyone whether they are able to sign with her or not. There are many members who know her signs; they are quick to interpret them for those who don't and to model signs everyone can use with her. Everyone is comfortable with the signs, because few are proficient and all are learning together.

Rachael is usually with a babysitter upstairs. She is not left out of the fun of the evening, however, because usually at least one child of one of the members of the gathering comes along. One night, Dena's son came to the gathering and on another evening, Margaret, Ann's daughter came. Now that it is warmer, the members of the gathering can hear the voices of the children playing in the yard; these remind us that soon, as she gets a little older and a little more mobile, Sarah will be out playing with other children rather than being the center of attention of our gathering. Connections are being made everywhere!

At one gathering, Sarah, with her instincts as a "ham," took center stage with her rendition of the "peanut song" (taught to her by Rachael). Some of the members of the gathering joined in the song, using words, signs, or both. Those who didn't join in applauded when she finished. The song was a wonderful glimpse of this little girl and what joy she brings to those around her. Another glimpse of the child known as Sarah was given when she attempted to pull herself to standing in order to reach the bagels and cream cheese set out for munching during the gathering. The group observed that bagels could be used in other settings to get Sarah interested in standing up independently!

The framework for Sarah's gatherings was established at the first meeting when everyone introduced himself or herself — some members had never met — and then described their own families, so that we knew each other as more than "the occupational therapist from Visiting Nurses" or as "the family services coordinator from the Beach Center." Each person also listed the three most important things in their lives. Family, friends, and productive work were repeatedly emphasized. These were important to each group member and also as components of our visions for Sarah's life.

The group meets in the family room of the Schaffers' home. Everyone, including Sarah, sits around, visits, and swaps stories as the gathering begins. There's food — pizza, bagels, sodas — and lots of laughter.

Great expectations

Successful businesses have long ago mastered the catalytic power of vision:

If any one idea about leadership has inspired organizations for thousands of years, it's the capacity to hold the shared picture of the future we seek to create.

The practice of shared vision involves the skills of unearthing shared "pictures of the future" that foster genuine commitment and enrollment rather than compliance. In mastering this discipline, leaders learn the counterproductiveness of trying to dictate a vision, no matter how heartfelt. (Senge, 1990, p. 9)

Conventional wisdom once held that being "realistic" about one's unfortunate circumstances was the hallmark of good mental health (Snyder, 1994). More recent writers, however, offer a different perspective, pointing out the advantages of a sense of optimism, hope, and vision over a narrowly defined "realism." Taylor (1989) notes:

Overall, the research evidence indicates that self-enhancement, exaggerated beliefs in control, and unrealistic optimism typically lead to higher motivation, greater persistence at tasks, more effective performance, and, ultimately, greater success. A chief value of these illusions may be that they help to create self-fulfilling prophecies. They may lead people to try harder in situations that are objectively difficult. Although some failure is certainly inevitable, ultimately the illusions will lead to success more often than will lack of persistence. (Taylor, 1989, p. 64)

Action Groups can foster great expectations in many ways, leading to new and empowering future visions. Some of these include:

- Affirming the child's strengths and projecting future scenarios that those strengths can create;
- Affirming the positive contributions that the child makes to group members (Summers, Behr, & Turnbull, 1989);
- Sharing stories of older children, youth, and adults with a similar disability who have been successful in accomplishing their priorities (Turnbull & Turnbull, 1993;
- Inviting parents of older children and youth with a similar disability to participate in the group and to share their "veteran" success (Santelli, Turnbull, Marquis, & Lerner, 1995);
- Fostering creative thinking characterized by a "what if" orientation rather then "yes buts"; and an "if we" orientation rather than "if only."

Great expectations can fuel hope and energy, leading to both stronger reliable alliances and more synergistic

communities (Turnbull & Turnbull, in press). When people feel that they are not alone and when partners are reliable allies with each other over the short and long haul, families and other group members perceive opportunities once believed to be "unrealistic" as within their power to influence.

Van and Rose are quick to point out, "It [the Action Group] helps us see more opportunities for her. There is such a sharing of ideas; each person sees something different, and we can use those ideas to plan for where we are going — today and in the future.

The group has one global great expectation for Sarah — that she will "have her shot" in her family, neighborhood, and community. A more specific vision is gradually being articulated. Van, Rose, and every participant are experiencing firsthand the catalytic power of shared visions — not for a life of "services," but for a future of playmates, birthday parties, sleep-overs and teenage telephone problems. Now Sarah's closest friend is Rachael, but in the years ahead there will be schoolmates, friends from the church, or Brownies. Sarah's productive role in life will start with her responsibilities in the family, to herself and to other members of the family. It will include helping with household chores or family projects, having collections and hobbies, and developing unique skills or talents that are rewarding to her both personally and socially. Later, she will have work that will be satisfying to her personally and provide the resources to meet her daily needs. Finally, the vision includes Sarah within a network of people who know her and in a community where her contributions and personal characteristics have long ago overpowered any "disability."

This is the visionary "Sarah". This vision will not be achieved by sitting back and having traditional expectations and receiving traditional services that are typically considered to be "realistic" for children with Down syndrome. Realizing the vision will involve working together and thinking creatively— but what a life it will be!

Members of Sarah's gathering also imagined a "nightmare vision." The nightmare was of Van and Rose standing at the brick walls of their neighborhood school, trying to break down that wall alone. Asked to create a vision from that nightmare, the group pictured Van and Rose, again at the wall, but this time together with all of us from their gathering , with the brick walls fading to open doors.

Of course, there are years before Sarah reaches kindergarten age. But it takes years for micro-, meso-, exo-, and macrosystems to change. In addition to Sarah's continued enrollment in the day care program and her routine family get-togethers with 40+ cousins, the members of the gathering will work to achieve expectations for her in other environments and experiences of early childhood. Swimming lessons, Sunday school, play groups, family vacations, "tag-alongs" with parents and old brothers or sisters, and trips to the Dairy Queen are part of growing up for young children. We expect that Sarah will enjoy all of these and more.

As the members of the gathering work together, our expectations will grow. Our current expectations are that Sarah will be included in the toddler room at her daycare center, that she will walk and run, that she will talk, and that she'll go to kindergarten. Bring together 15 emotionally connected people into a synergistic context, and who knows what can grow out of it? We're early in our thinking together; and once we're on a roll, our expectations will grow and challenge each and everyone of us to act with Sarah, her family and each other.

Solving problems

Problem resolution is a key aspect of Group Action Planning—it connotes the "action" portion of this process. Having a reliable alliance with group members is not an end in itself, but rather a means to translate visions into reality.

Many support groups are able to take little action because their structure does not include a systematic problem-solving process. Action Groups incorporate this process through the role of the group facilitator, who skillfully (but with a light touch) moves the group through the steps of (a) identifying and prioritizing child and family needs, (b) creatively brainstorming a broad range of options, (c) evaluating the benefits and drawbacks of options and selecting the most appropriate one to implement, (d) developing a specific plan for assigning responsibilities and creating timelines, (e) implementing the plan, and (f) evaluating the outcomes (Knackendoffel, Robinson, Deshler, & Schumaker, 1992; Shank & Turnbull, 1993).

Although many support groups and early intervention programs focus solely on individual and family skill development, Group Action Planning gives just as much emphasis to ecological change. For great expectations to come true, it may be more necessary for the environment to change than for the individual and/or family to learn new skills. Specific problem-solving strategies used in Action Groups include:

- Having a facilitator who has refined skills in the problem-solving process and in facilitating discussion so that positive relationships are fostered among all group members;
- Proceeding through the steps of problem solving, incorporating the expertise and resources of every group member;
- Recognizing when guests need to be invited to the Action Group to help solve a particular ecological problem (e.g., the principal of Sarah's neighborhood school is invited to attend to brainstorm about the supports that need to be put into place so that Sarah can most successfully be welcomed into the school);
- Distributing the responsibility for follow-up tasks among all group members so that no one is overwhelmed;
- Sending out a "to-do list of next steps" about a week after the meeting, outlining tasks what each person will accomplish prior to the next meeting;

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Four Levels of Ecological Partnerships

1. Microsystem impact—influencing settings in which the majority of the activities, roles, and interpersonal relationships of the child and family occur (e.g., at home with siblings and extended family; within neighborhood with peers and babysitter).
2. Mesosystem impact—influencing interactive environments in which the child and family participate (e.g., home and early intervention programs; home and YMCA; home and church/synagogue; home and parents' workplace).
3. Exosystem impact—influencing settings that strongly impact the child and family but which they do not actively participate (e.g., the city parks and recreation department offers numerous opportunities for young children to participate in recreation, but almost all of the activities are not accessible to a child with a severe disability; community preschools that do not provide inclusive opportunities for children with disabilities).
4. Macrosystem impact—influencing community values (e.g., community leaders who most strongly shape community opinion regarding respect for diverse populations; feature editors from the local newspaper; members of the school board).

- Monitoring follow-up to ensure that consistent progress is made from one meeting to another, with each person needing to complete only one or two tasks;
- Reviewing the "to-do list" from the previous meeting at the subsequent meeting so that all group members are accountable for accomplishing and reporting on their progress.

One of the key tasks of the group is to model, practice, and refine problem-solving skills so that everyone becomes more competent in this domain. Including a broad array of stakeholders with diverse expertise enriches the brainstorming phase of problem-solving. Communication skills can grow and flourish within Action Groups. When people perceive that they do have genuinely reliable allies in problem-solving, the group experiences a tremendous surge of hope, energy, and persistence.

In Sarah's child care program, children between 14 and 18 months of age routinely transition from the infant room to the toddler room once they begin to walk. Sarah may not reach that milestone within that age window. Van and Rose were distressed that she would have to remain in the infant room beyond the usual time frame and see the children she knew as friends move out of her area. When the issue came up at the gathering, Shelly, the director of the child care program, was quick to say that Sarah could "move up" whenever it seemed appropriate if she could manage the older room safely (not get trampled!) If all the other toddlers are walking, is Sarah more likely to be stepped on or to be encouraged to get up and walk out of the way, since everyone is modeling walking for her? This discussion illustrates how Action Groups work on environmental change rather than assuming that the child has to conform to traditional requirements (e.g., achieving the specific developmental milestone of "toddling" in order to join the toddler group.)

The members of Sarah's gathering went to work to come up with a way to try out the new setting while not upsetting the child-teacher ratio required for the room by the state child care licensing agency. What seemed best was for Sarah's speech-language therapist (Matt) to take her to the toddler room and use this setting as the environment for his therapy with her. The new room would provide many new things to talk about; at the same time, Matt would provide support for staff in the use of signing, model signing for the other children, and maintain the ratio of children to adults.

Later, Lance, the toddler room teacher, asked the Action Group for more problem solving, because he had not been in the room when Sarah, Matt, and Jane, Matt's supervisor, visited. The plan was then revised so that one day a week Matt and Jane go to the child care center when Lance is working. This way Lance can get to know Sarah better, although he says, "I'm ready now," and Sarah already knows and uses his name sign!

Issues that may arise as the Action Group members work toward their vision for Sarah include: 1) how to provide transdisciplinary services as her skills increase and diverge along more traditionally separated developmental domains; 2) how to facilitate Sarah's inclusion in settings other than home and child care; and 3) how to balance the family's focus so that all family members can achieve their individual as well as family goals.

Rose recognizes the Action Group's powerful support. "We met with the staff of the day care the other day about Sarah's transition to the toddler room. It was so nice to be able to say [when some issues were raised], 'Let's take it to the group meeting.' We can bring the question to the group meeting to talk about the best way to go."

Celebrating progress

Especially when significant individual and ecological change is needed, families often feel overwhelmed by the tasks yet to be accomplished. When this happens, team meetings and support groups tend to focus only on needs and problems rather than offering genuine opportunities to celebrate progress. An essential and defining feature of Group Action Planning is incorporating celebration on a frequent basis.

There are many different ways to celebrate progress, including:

- Affirming at each meeting the steps that have been made in problem-solving to resolve significant child and family needs;
- Celebrating milestones such as the 6-month anniversary of being included in a neighborhood play group or a one-month anniversary of attending the church preschool;
- Having "we've come a long way, baby" conversations to compare the opportunities for the child and family when the group started to the current situation (Wills, 1987);

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- Having parties, ceremonies, and rituals for acknowledging the reliable alliance that has been mutually formed and the progress that is being made;
- Celebrating the special occasions in the lives of every group member and genuinely extending care and empathy during the joys and sorrows that they experience;
- Seeking opportunities to enhance the self-efficacy of each group member by focusing on their unique contribution to the Action Group.

Celebration is a catalyst for forming synergistic communities, because it can reduce the stress associated with the hard work of problem-solving and foster a sense of collective and mutual empowerment. Celebration often renews energy and, therefore, can lead to greater persistence over time.

Celebrating progress is easy in this gathering. Sarah is doing well; she has a signing vocabulary of 75+ words, uses some couplets, and pulls herself to standing without help. She has also created her own home signs, including one for trouble! Her family is doing well; Rachael enjoys pre-school with lots of friends and teaches signing to any child or adult she encounters. Van and Rose feel good about the progress both girls are making.

The members of the gathering also celebrate each other's progress toward their goals — the big ones (Matt has been accepted for graduate school at the University of Arizona) and the small ones (Dena got herself and her family all dressed and out the door at the same time one day last week!)

We're looking forward to future celebrations also. Sarah is going to walk; Kay showed everyone how to facilitate her progress toward those first steps. She's also going to talk; Ann demonstrated games she had used to interest her daughter in vocalizing. She suggested a variation on "singing in the shower" — tapping the "robust acoustic qualities" of the shower and also vocalizing into an inflated balloon, held on her lap for the tactile feedback from the balloon's resonance of the sounds.

Other celebrations can be visualized. Sarah is going to take swimming lessons with kids her own age. She enjoys swimming with Rose now, but think of our celebration when she floats independently! Given the way children are rushed to competition in our culture, there probably will be a community floating contest. She's got a head start on winning!

Team members will progress, too. We'll all get better at sharing our expertise, and we'll come up with even better ways to support Sarah, Rachael, Rose, and Van to ensure that Sarah gets her shot at life. Through the process, we'll also enhance our own "shot at life."

Summary

What will the year 2000 be like for Sarah as she enters kindergarten in her neighborhood school? Will the brick walls be impregnable, or will the open doors be welcoming? Will Sarah's identity across ecological environments primarily be "the little girl with Down syndrome" or will it be "Sarah — the daughter, the sister, the niece, the cousin, the granddaughter, the neighbor, the friend, the Brownie, the swimmer, the playmate, the "ham", the student, the citizen? Will Sarah truly have her "shot in life" as a full citizen of her community, or will she experience second-class citizenship? Will her life be characterized primarily by formal services and inter-agency coordination or by formal and informal supports and inter-community resources? Many of the traditional services for young children with disabilities and their families have pointed to one type of existence, but Group Action Planning holds a whole different promise for Sarah, her family, and all families who choose to develop reliable alliances and synergistic communities. As Mike Ruef, a member of an Action Group that has been ongoing for several years, commented:

As Americans, we are raised to be independent and self-sufficient. What we often don't realize (in my case I was over 35 before I realized it) is that we need each other; we need community. While I know some members of the Action Group better than I know others, I have a feeling that I can go to any of them for help, because we are all on the same wavelength. These people are my safety net, my reliable alliance. Although I have been a contributor, Group Action Planning has never felt like an "obligation." Rather, it enriches me and has become an essential part of my life. (Turnbull & Turnbull, in press).

Relationships are reciprocal. This is a key synergistic and rejuvenating feature of Group Action Planning for Rose and Van, Sarah, Rachael, and every other participant. In fact, Group Action Planning holds promise for "getting a shot at life" for many families.

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Note: Readers interested in more detailed guidelines for implementing Group Action Planning can contact the Beach Center on Families and Disability at 3111 Haworth Hall, University of Kansas, Lawrence, KS 66045.

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Beyond the Pizza Dinner:

"Natural" Alternatives to Parent Support Groups

Tracy Price Johnson, B.A., MBA (but most importantly, single parent of Hayley and Hayden), Coordinator, Project ACCESS

Lucy Jane Miller, Ph.D., OTR, Assistant Professor, Department of Pediatrics

University of Colorado Health Science Center, Denver, Colorado

We can remember when "support" for parents of children with special needs came in the form of a lecture by a professional expert once a month. Then came pizza dinners, where everyone sat around in a circle and the whole thing was "facilitated" by a professional. But in the corner, one mom could ask another, "Is there any way I can drop Joey off with you one evening?" Parents had established a level of comfort with each other where asking for "help" from one another was not perceived as "needy" but as natural. Would you believe "parent support" in the form of a sleep-over for single moms and their kids with special needs, with lots of old music and everybody dancing? This is an idea that began when three single moms wanted to connect, cut loose, and let their children have fun together, too. Over time, the party has grown to include eight single moms and 22 kids on a rotating basis. The sleep-over turned out to be a great way for mothers who are carrying the full load of responsibility for their children to "unload" for once. And the sleep-over didn't become a gripe session —it was a way to begin building enduring, sustaining relationships.

From our point of view, relationships—sturdy, emotionally meaningful connections—are what truly support people, whoever they are—children, adults, and families with children with special needs. In our experience, real support comes most frequently from relationships that develop naturally. A chance to have ordinary fun—at a sleep-over, a picnic, or a swimming session—brings people together. When families are doing things together that they enjoy, connections happen.

Natural connections are a big part of both Project ACCESS and Project ENRICH, an initiative designed to develop a model of helping families and caregivers integrate therapy for young children with severe sensory and motor problems into daily routines, play, and community activities. The parents and professionals who planned and are implementing the project wanted to explore alternatives to the traditional "parent support group." Our goal has been to create opportunities for relationships to flourish naturally, and to break down artificial barriers—between parents with typically developing children and parents whose children have a disability, and between parents and professionals.

"Community Days Out" are one alternative to traditional parent support groups that we have tried. Every month, Project ENRICH sponsors an event that is open to participating families and to participants in other programs serving families with infants, toddlers, and young children. For example, a recent excursion to Denver's butterfly museum drew 20 families. Families talked to each other as they enjoyed the museum—one mother, for example, said that she wanted to send her child to school with his powered wheelchair but couldn't get it out of the house; another mother said that the Boy Scouts will build a ramp if you ask them. Snacktime (a feature of every Community Day Out) provides a great opportunity for families to learn feeding techniques from each other—naturally as well as to socialize.

Community Days Out can be planned on a grand scale or a small one. To organize a schedule of monthly events that are appealing to families, we rely on a parent who is paid for the time involved in arranging excursions (making sure, for example, that Santa at the mall is accessible and that admission fees can be waived) and sending out invitations every month (families who can't attend or aren't interested in one month's event know that another invitation will come in a few weeks.) Responsibility could also be passed around within a group of parents—the important thing is to be clear about who has lead responsibility.

As parents on Community Days Out have seen their children having fun like "normal kids," they have felt better about themselves and about being with other families. They have begun to plan less structured get-togethers—the sleep-over, for example, and multi-ethnic pot-luck picnics, and a now-legendary "wheelchair derby" in a local park featuring small children equipped with both wheelchairs and state-of-the-art voice-activated water pistols. When parents of children with special needs and professionals all bring their family members to such an event, the occasion becomes, as one parent tactfully put it, "a great equalizer." (Translation: An advanced degree in physical therapy doesn't mean that you can control your own two-year-old.)

An evening or weekend event that is open—and appealing—to everyone's family can smash stereotypes about parents and professionals and break down formidable logistical barriers at the same time. We have

learned, for example, that weekday "Community Days Out" are difficult not only for working parents, but also for families whose lives include complicated therapy schedules for children. Events scheduled on evenings and weekends, however, take professionals away from their own families. But a swimming party or a water-pistol shoot-out can appeal to any family with young children; professionals who are parents may be delighted to attend an evening or weekend event when they can bring their own families along.

Our experience in fostering "natural" connections among parents in Project ENRICH has helped us recognize similar opportunities in other contexts. For example, Stacey, a participant in the project, is a teen mother whose baby, Kara, has severe disabilities. Stacey attends high school with other teen moms, and her daughter is enrolled in the on-site child care center. Not one of the other young mothers had ever asked Stacey about her baby. One day, Stacey told us that a teen/tot swimming session had been scheduled at school. She wanted to go, and to bring Kara, her daughter. School personnel refused—until we and Stacey made the argument that it would be a tremendous "therapeutic opportunity" for Kara to play in the pool with her mother, an occupational therapist, and a physical therapist.

It is conceivable that the afternoon at the pool affected Kara's muscle tone and neural plasticity. It is definitely the case that the afternoon helped Stacey and her classmates make important parent-to-parent connections. This was a "day out" for Stacey in her own community of young mothers—people whom she saw daily but from whom she had felt emotionally, if not physically, apart.

Thinking about our middle-aged selves in the high-school swimming pool with a bunch of adolescent mothers and their babies reminds us of an occupational therapist colleague, Lois Hickman, who moved to a farm in rural Colorado some time ago. She still does occupational therapy with children, but it's been different since she left her office. Now kids come to the farm for the whole day; they climb ladders, shovel hay, and find eggs. Tactilely defensive kids practice holding roosters. Everyone crawls around in the mud. Since several children come to the farm at a time, their parents have a chance to network. How could we replicate this experience in Denver? Well, maybe Project ENRICH could sponsor a community garden . . . maybe we could use some of the lawn next to The Children's Hospital . . . is mulching reimbursable through managed care?

Support for parents can take many forms—and people will find endless ways to create sustaining connections with each other if they can get some help in busting the barriers between them. As for us, we've got to stop—we're leaving the pizza to the kids and are on our way to grab a salad with a Project ENRICH working mom on her lunch hour. . . .

16 Years of *Zero to Three* Articles on Parenting Groups

Zero to Three has been publishing articles on parenting groups since its very first issue appeared in September, 1980. Reviewing all 16 volumes of *Zero to Three*, we found a total of 45 articles that describe parenting groups in a range of contexts, discuss their design or place within a continuum of services, or address specific issues (for example, curriculum or leadership). Each article is listed below, with title, author, and date of publication.

Readers may use the form on page 44 to order photocopies of these articles, identified by number, by mail, phone or fax from ZERO TO THREE.

1) Program Profiles: Family Focus, Inc.
Vol. I, No 1, Sept. 1980, p. 4

2) Program Profiles: PIPS—Los Angeles
Vol. I, No 2, Dec. 1980, p. 6

3) Program Profiles: Child Development Resources Lightfoot, Virginia,
Vol. I, No 3, Mar. 1981, p. 5

4) The Infant Care Center as a "Home for Parents"—Christina Sekaer and Virginia Flynn
Vol. 1, No 4, June. 1981, p. 2

5) The Rural Family Support Project: Community Ownership of Primary Prevention Programs—Nancy Warren
Vol. III, No 3, Apr. 1983, p.6

6) Caring for Infants With Respect: The RIE Approach —Magda Gerber
Vol. IV, No 3, Feb. 1989, p.1

7) The Capacity for "Enabling" in Mentally Ill Mothers—Judith Musick, Frances Scott, Katherine Spencer, Judith Goldman, & Berham Cohler
Vol. IV, No 4, Apr. 1984, p.1

8) The Infant Care Program at Evanston Hospital: Putting Research to Work—Carol Ceitham
Vol. V, No 2, Dec. 1984, p.1

9) The Toddler Group: A Setting for Adaptive Social/Emotional Development of Disadvantaged One and Two Year Olds in a Peer Group—Billie K. Press & Stanley I. Greenspan
Vol. V, No 4, Apr. 1985, p. 6

10) Families in Early Intervention: Effects of Program Variables—Mary A. Moran
Vol. V, No 5, June. 1985, p. 11

11) The Post-Partum Support Project: Serving Young Mothers and Older Women—Elizabeth Anisfeld and Madeline Pincus
Vol. VIII, No 1, Sept. 1987, p. 13

12) Parents with Physical Disabilities and Their Babies —Megan Kirshbaum
Vol. VIII, No 5, June. 1988 p. 8

13) The Professional Use of Self in Prevention—Judith Bertacchi and Julie Coplon
Vol. VIII, No 5, June. 1988, p. 1

14) Recurring Questions for Family Support Practitioners—Marilyn Segal, Roni Leiderman, and Wendy Masi
Vol. IX, No 4, Apr. 1988, p. 8

15) The Effectiveness of a Feeding Support Group in An Early Intervention Program—Lisa Ingelfinger
Vol. IX, No 4, Apr. 1989, p. 12

16) Promoting the Health and Development of Drug-Exposed Infants with a Comprehensive Clinic Model—Barbara Tittle and Nika St. Claire
Vol. IX, No 5, June. 1989, p. 18

17) Infant Parent Intervention with Recent Latino Immigrants—Alicia F. Lieberman
Vol. X, No 4, Apr. 1990, p. 8

18) Serving The Newest Arrivals: A Model of Early Intervention for Central American Babies and Their Families—Maria Elena Orrego and Ann Barnet
Vol. IX, No 4, Apr. 1990, p. 11

19) Preventive Intervention Groups with Adoptive Parents and Their Babies: Minimizing the Risks to Emotional Development in the First Three Years—Elaine Frank and Denise Rowe
Vol. X, No 5, June. 1990, p. 19

20) Training and Supporting Leaders of Mother-Baby Groups: The P.A.C.E. Approach—Barbara Conte, Erica Moltz, and Eileen Solomon
Vol. XI, No 2, Dec. 1990,p. 17

21) Rising Above The Past: Strategies for Helping New Mothers Break the Cycle of Abuse and Neglect—Byron Egeland and Martha Farrell Erickson
Vol. XI, No 2, Dec. 1990, p. 29

22) Stories for the Shelter: Introducing Books for Very Young Children to Parents and Staff—Nancy Johns and Catherine Harvey, with Sharon Glickman-Kind
Vol. XII, No 1, Sept. 1991, p. 21

23) Family Literacy: Serving Undereducated Families—Bonnie Lash Freeman
Vol. XII, No 1, Sept. 1991, p. 27

24) Finding Common Ground: Facilitating A Therapeutic Group for Diverse Parents of Young, Disturbed Children—Lesley Koplow
Vol. XII, No 3, Feb. 1992, p. 27

25) CHILDSPACE—Creating an Environment of Respect for Infants, Toddlers and Caregivers of Children—Jane C. Warrent, Carla Oswald Reed, Susan Manker-Seal, and Lani A. Comp
Vol. XII, No 4, Apr. 1992, p. 21

26) Introducing Parent Support into Residential Drug and Alcohol Treatment Programs—Cathie Harvey and Marilee Comfort, with Nancy Johns
Vol. 13, No 1, Aug./Sept., 1992, p. 11

27) Working with Addicted Women in Recovery and Their Children: Lessons Learned in Boston City Hospital's Women and Infants Clinic—Margot Kaplan-Sanoff and Kathleen F. Rice
Vol. 13, No 1, Aug./Sept., 1992, p. 17

28) Babies in Prison—Jean Harris
Vol. 13, No 3, Dec. 1992/Jan 1993, p. 17

29) Treating the Relationships Affected by Postpartum Depression: The Group Therapy Model—Roseanne Clark, Anne P. Keller, Sharon S. Fedderly, and Andrew W. Paulson
Vol. 13, No 5, Apr./May 1993, p. 16

30) Previewing: An Intervention Strategy for Psychiatrically Ill Parents of Infants and Toddlers—Paul V. Trad
Vol. 13, No 5, Apr./May 1993, p. 25

31) Providing Integrated Treatment for Parent/Infant Dyads At Risk because of Parental Emotional and Mental Illness—Barbara Munk
Vol. 13, No 5, Apr./May 1993, p 29

32) Personal Narratives and the Process of Educating for the Healing Partnership—Elaine Walizer and Patricia Leff
Vol. 14, No 1, Aug./Sept. 1993, p. 21

33) Infant Massage—Tiffany Field
Vol. 14, No 2, Oct./Nov. 1993, p. 8

34) Not Telling Parents How To Raise Their Children—Rachel Theilheimer
Vol. 14, No 4, Feb./Mar. 1994, p. 1

35) Life Is Difficult - Let's Play First—Maria Elena Orrego
Vol. 14, No 4, Feb./Mar. 1994, p. 7

36) Parent-Professional Relationships: Finding an Optimal Distance—Gilbert M. Foley, Jane Hochman, and Susan Miller
Vol. 14, No 4, Feb./ Mar. 1994, p. 19

37) Join My Dance—Suzi Tortora
Vol. 15, No 1, Aug./Sept. 1994, p. 1

38) Attuning to the Fetus and the Young Child: Approaches from Dance/Movement Therapy—Susan Loman
Vol. 15, No 1, Aug./Sept. 1994, p.20

39) The People of Kids Place—Carolyn King
Vol. 15, No 5, Apr./May 1995, p. 10

40) Group Well-Child Care as a Method of Providing Developmental Guidance in Pediatric Care Settings — Lucy Osborn
Vol. 16, No 1, Aug./Sept. 1995, p. 10

41) The Soho Parenting Center—Lisa Spiegel and Jean Kunhardt
Vol. 16, No 1, Aug./Sept. p. 18

42) The Touchpoints Model: Building Supportive Alliances Between Parents and Professionals
Vol. 16, No 1, Aug./Sept. 1995, p. 24

43) Keys to CaregivinG: A New NCAST Program for Health Care Providers and Parents of Newborns—Georgina Summer
Vol. 16, No 1, Aug./Sept. 1995, p. 33

44) The Early Childhood Program: Promoting Children's Development through and within Relationships—
Carol Klass, Karen Guskin, and Jean Thomas
Vol. 16, No 2, Oct./Nov. 1995, p. 9

45) Grandparent to Grandparent Forums: Strengthening Ties among the Generations—Barbara Bowman
Vol. 16, No 4 Feb./Mar. p. 18

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Letters

❦ To the Editor:

I enjoyed the February/March 1996 issue on grandparenting both on a personal and professional level. All the articles were of great interest. The issue has made a nice memento for several new grandparents.

In addition to the children's books cited by Barbara Bowman (Grandparent to Grandparent Forums: Strengthening Ties among the Generations) I recommend the following books as resource for discussion with grandparent groups.

De Paola T., *Now One Foot, Now the Other*. New York: Putman, 1980.

Griffith, H. *Grandaddy's Place*. New York: Mulberry Books, 1987.

Hammer Ross, L. *Buba Leah and Her Paper Children*.Philadelphia: Jewish Publication Society, 1991.

Hoffman, M. & Binch, C. *Amazing Grace*. New York, Dial Book, 1991

Martin B., Archambault, J. *Knots on a Counting Rope*. New York: Henry Holt.

Placco, P. *The Keeping Quilt*. New York: Simon & Schuster, 1988.

Schwartz, A. *Oma and Bobo*. New York: Harper & Row, 1987.

Ward, S.G.*What Goes Around . . . Comes Around*. New York: Doubleday, 1991.

Best wishes!
Hedi Levenback, C.S.W.
Bronx, New York

❦ To the Editor:

I would like to applaud *Zero To Three* for a feature article (October/November, 1995) on the role that consultation plays in the work-life environment. I was in complete agreement with the author's perspective on a company "doing it right" every time they consider offering a child care program. I am an early childhood educator who has worked with children and their families in a variety of settings for a number of years. For the past three years I have worked as a director in an "emergency back up" child care center.

I would like to address the questions raised by Margery Leveen Sher regarding back up care. Back up care is intended to supplement regular child care arrangements and assist families when their normal child care arrangements breakdown or became unavailable. Currently, Children First Inc. is the only national company focusing exclusively on back up child care. We partner with corporations to support working parents and help them through potentially stressful situations. Children First has developed a program based on the developmental needs of children between the ages of 6 weeks and 12 years of age.

It is a priority for Children First staff to provide parents with a sense of comfort in the caregivers with whom they entrust their children. I agree wholeheartedly with the author when she states that one of the most important aspects of any child care program is a "stable, well-trained and dedicated staff and director." At Children First Inc. it is implicit and explicit goal to hire and maintain the highest quality staff. The expectation is that all teaching staff hold, at minimum, an undergraduate degree in education or a child-related field; and each center administrator holds a master's degree in education or a child-related field. All staff receive initial and continual training on issues specific to child development, working with parents, and the specialty of back up care.

Ms. Sher raised very valid questions about emergency back up care in her article. I would like to highlight how we at Children First address some of these issues.

How are children made to feel comfortable coming into a strange place?

All staff at Children First are sensitive to the needs of, not only the child, but also the parent. It is imperative that both a parent and child feel safe and secure in this new environment. If parents are uncomfortable with their child care arrangements, how productive can they be at their worksite?

Several activities are designed and implemented by our staff to promote a family's comfort in our environment. We begin this process by offering the parents a thorough presentation of Children First, back up care, and the curriculum we provide in our Centers at an on-site presentation. During these presentations parents have the opportunity to ask questions about the Children First curriculum, program, logistics, and the teachers in our Centers.

Following the presentation we invite all participating employees to visit our facility and meet the staff. Parent gain a sense of trust when they observe our security systems (such as a full time security guard, intercom system, security cameras, monitors, etc.), developmentally appropriate play areas, and most importantly, when they meet the staff.

Recognizing that child care is a family issue we follow this up with a weekend open house called a "Family Day." This "Family Day" allows the family as a whole to explore the Center in a fun-filled day. This day offers entertainment to families such as a magician, storyteller, face painting and artistic activities. Children and parents have the opportunity to create a picture frame for a photograph that will be taken of both of them. This very special frame and photograph goes home with the children and helps them to remember the center as a familiar place when they must return during a breakdown in their normal child

care. This photograph is a tangible reminder in the child's home of the Center.

Once the Center is open and a family has successfully completed the registration process, a family is invited to an "Introductory Visit." The intent of this visit is to allow the parent and child to "practice" the commute and what the experience of separation may be for parent and child. Parents are encouraged to come on a day when their schedule may be more flexible so that they have the flexibility to visit their child, as is convenient throughout the day.

In an effort to create a comfortable and friendly environment children are strongly encouraged to bring a special toy or transitional object from home. Children also have the ability to phone or fax parents from the Center if a check-in with a parent is needed. Children also have the opportunity to visit their parent's worksite during lunch.

What sanitation procedures are used to eliminate problems arising from different children using the facility each day?

Extra care and special considerations are given to issues of health, safety and sanitation in our Centers.

- All staff are trained in first aid, CPR and OSHA to prepare a teacher to respond to a health or emergency situation.
- All children must have a current physical exam on file (making sure to meet all licensing rules and regulations).
- Centers have a health and illness policy which does not permit sick children to attend the program, and if a child becomes ill throughout the day they are sent home.
- Strict sanitary policies are in place for staff, including diapering/toileting policies and procedures.
- All toys and equipment are properly sanitized and cleaned throughout the day as needed.
- All of our facilities have a pediatrician available to them on an "on call" basis for any medical concerns or questions.
- Children are assigned their own cubby, crib or cot, and diaper storage area. All food and bottles are labeled with a child's name.

The above highlights some of the procedures and policies in place to aid in minimizing the spread of infectious diseases and maintaining a healthy environment for all.

Should infants and toddlers be admitted, or is a group program like this too much emotionally for children going through stranger anxiety?

Separation is one of the main developmental issues we see in our facilities. As a group of trained professional teachers and administrators we are aware that one of our responsibilities is to support children and families through separation and/or stranger anxiety. All staff receive training specific to the issues of separation, being aware that any age child goes through such a process. We want each visit to our Centers to be as non-stressful for the parent and the child as possible, as we do not want to be a disruption to the child developmentally. In order to do this, we ask parents in the morning when they arrive to fill out a child information sheet, which provides staff with very pertinent information about the child, their routines and any other critical information. All infants and toddlers are assigned a primary caregiver for their day with us, and when possible this teacher will be available to the child on his/her next visit. Our intent is to minimize the number of unfamiliar interactions for that child and help foster a trusting relationship for both parent and child with the staff.

As noted earlier, many of our facilities are located at or near the worksite so parents are encouraged to visit throughout the day. We highly encourage a visit if this would help a parent or child's adjustment.

For many families who have relocated to a new city for business our Centers may be their only support for childcare. A parent can have a sense of comfort in knowing their child will be cared for by a professional, nurturing child development specialist or teacher.

I hope the above information helps to highlight a company that does have "children first" as their priority and sets the nurturance of children and families as one of their values. I would welcome any further questions or the ability to discuss Children First and back up child care further.

Sincerely,
Myra Oria, M.Ed.
Transitional Director, Children First Inc.,
One International Place, Boston, MA 02110-2624
(617) 951-7820

To the Editor:

As regional Coordinator of our State's Early Intervention program, Sooner Start, I have been pleased with your bi-monthly publication of *Zero to Three* and enjoy sharing it with our other E.I. team members. Since we are serving some infants and toddlers who are in the home of their grandparents, we found your February/March bulletin of particular interest.

As a new first-time grandmother (son of my first-born son), I also found "There Will Always Be Lullabies" speaking directly to my heart as I experienced many of the same emotions. Please express my personal thanks to Ms. Weissbourd.

Keep up the good work. Your connection of theory with current clinical practice in the "real world" provides us with helpful and practical information. I also find your articles are helpful in educating newcomers in the field.

With sincere thanks,
Linda Adams, M.A.
Regional E. I. Coordinator, State Department of Education, Pittsburgh County Health Department
McAlester, OK 74501

Publications

Happy Birth Day (1996)—Robie H. Harris, illustrated by Michael Emberly (Candlewick Press, 2067 Massachusetts Avenue, Cambridge, MA 02140) $16.99.

Writing about the day of birth for children and their families, Robie Harris, author of *It's Perfectly Normal* and *Before You Were Three*, observes that her own children "loved hearing about all the things they could do on the day they were born." Harris and illustrator Michael Emberly researched each detail of the text and the large, realistic paintings that illustrate the book, even attending a birth together. Thus in one illustration, a drop of sweat falls from the cheek of the mother who reaches for her newborn, still attached by the umbilical cord. Nursing for the first time, the baby gazes intently at the mother, who says, *"You began to whimper, and suddenly you were awake. I picked you up and you snuggled into my shoulder. But then your lips began to quiver and you opened your mouth and cried. I thought you might never stop! But as I gently stroked your cheek, you took a big deep breath—and stopped. Then you squiggled up your nose and began to nurse. You made such sweet smacking sounds! Daddy said you sounded like a baby goat."*

Children in Jeopardy: Can We Break the Cycle of Poverty? (1996)—Irving B. Harris (The Yale Child Study Center, distributed by Yale University Press, New Haven, Connecticut 06520) $27.95.

"I have learned most meaningfully from personal contact," observes businessman and philanthropist Irving Harris. In *Children in Jeopardy*, Harris acknowledges dozens of elected officials, public servants, scholars and scientists, and others who have stimulated him "to think constantly, and sometimes obsessively, about the problems of poverty, school drop-out, and early childhood learning" in the United States. This volume, in turn, offers Harris' personal perspective on these problems, a perspective developed over 40 years of study, advocacy, program development, and action research. Harris examines difficult issues, including the limits of intervention; sex education, contraception, and abortion; and the interrelationships among education, poverty, violence, and punishment. He also chronicles the design, implementation, and evaluation of major intervention programs targeting high-risk families with infants and toddlers, including the public-private Ounce of Prevention Fund and the Center for Successful Child Development (the Beethoven Project). Calling for a new war on poverty, Harris advocates for appropriately intensive (and therefore costly) services for families with multiple problems. He emphasizes the importance of training highly skilled public health nurses, nurse practitioners, early childhood development specialists, social workers, and paraprofessionals, noting that, "even if we had all the money necessary to mount huge programs, it would take us at least ten years to prepare and train needed personnel."

The Vulnerable Child: What Really Hurts America's Children and What We Can Do about It (1996)—Richard Weissbourd (Addison-Wesley Publishing Company, Reading, Massachusetts) $22.00.

Begun as a joint project with Mary Jo Bane and drawing on interviews with hundreds of children and professionals, this book finds an interactive model—that is, the interaction between children's temperaments, coping strategies, and primary vulnerabilities and strengths and their caregiving environments—most successful in explaining the "real roots" of children's success and failure. Moreover, at "critical junctures," such as birth and entry into kindergarten, children are vulnerable to problems and setbacks that are difficult to overcome. Weissbourd argues that interventions at these points can make a huge difference in promoting children's cognitive and social development. These strategies are more likely to be effective if they strengthen parents; build on families' strengths; respond to the needs of all vulnerable children (creating constituencies across race and class lines); increase professionals' capacity to identify and respond to complex, interacting factors; and enable professionals to sustain attention to children's difficulties over time.

Weissbourd describes examples of effective health, education, child protection, police, and family support services, as well as the principles and practices that characterize them. The principles of effective health care for vulnerable children include, for example, providers understanding how children's health is related to attributes of their families and communities and providers responding to root problems, instead of treating every symptom, and looking for "leverage points that can set in motion positive cycles of success."

Map and Track: State Initiatives for Young Children and Families (1996)—Jane Knitzer and Stephen Page (National Center for Children in Poverty, Columbia University School of Public Health, 154 Haven Avenue, New York, NY 10032) $19.95, including postage and handling. Checks should be made payable to Columbia University.

In 1995, the National Center for Children in Poverty undertook a project to "map" state initiatives for young children and families and to develop a framework that would enable NCCP to "track" changes in those initiatives over time. *Map and Track* is planned as a biennial report, with each edition highlighting changes within individual states, as well as national trends. More specifically, the report focuses on special, state-initiated, comprehensive program and cross-system planning efforts. Thirty-seven states are currently supporting one or more state-funded comprehensive program strate-

gies explicitly targeted to young children and their families.

Highlighted in a profile of each state are: **program development** (including comprehensive program initiatives for infants and toddlers and family support programs); **planning** (comprehensive, and focused on early care and education); state-by-state **strategic approaches**; state-by-state **indicators of risk factors** (poverty, low birthweight, women not finishing high school, unemployed men, overcrowded housing); and **state investments in young children and families** (as measured by eligibility level for Medicaid for young children, state-funded supplemental health insurance, state-funded prekindergarten, use of state dollars to supplement Federal Head Start funds, training requirements for center- and family-based child care providers, and early childhood [0-5] education teaching certification).

Baby & Me: The Essential Guide to Pregnancy, Third Edition (1996)—Deborah Davis Stewart (The Willapa Bay Company, 726 Belmont Place East, Seattle, WA 98102) $16.95, also available in Spanish.

Designed to encourage women to take personal responsibility for their pregnancies and focusing on preventive measures, this spiral-bound book with worksheet pages has been purchased as a health education tool by health maintenance organizations, insurance companies, self-insured employers, unions, clinics and hospitals, public health departments, case management companies, and teen pregnancy programs. Reflecting new research and changes in perinatal care, the third edition of *Baby & Me* emphasizes folic acid and HIV testing as well as the benefits of a nursing home visit after childbirth. A revised and expanded chapter on caring for the newborn describes state changes in non-technical terms, emphasizing that "crying is a natural way for your baby to tell you something." The book offers ways for fathers to take an active role during pregnancy, childbirth, and infant care. Medical and other terms are defined within the text and in a glossary; "tips" advise on how to get WIC, deal with swollen feet, solicit help from family, and play with a newborn.

Family Careers: Rethinking the Developmental Perspective (1996)—Joan Aldous (SAGE Publication, Inc., 2455 Teller Road, Newbury Park, California 91320) $59.95 hardcover, $27.95, softcover.

This volume represents an effort to demarcate the expectable sequences, transitions, and outcomes of various contemporary family configurations, including cohabiting couples, single-parent families, stepfamilies, and homosexual families. The first part of the book presents a "family careers perspective," discussing the family as a social system, family roles, and developmental tasks for families and individuals. Subsequent sections of the book examine couple, parent-child, and sibling relations over time. The author observes that fragility is characteristic of today's families and that while the mother-child bond is central, the position of the partner-father is the most tenuous one in the contemporary family.

Empowerment and Family Support (undated)—Mon Cochran, editor (A Cornell Cooperative Extension publication [Cat Code 321EFS], available from Media Services Resource Center, Cornell University, 7 Cornell Business and Technology Park, Ithaca, NY 14850) $9.00, including postage and handling within continental U.S.

This volume includes six issues of *Empowerment and Family Support*, a networking bulletin produced from October, 1989 - June, 1992 by the Cornell Empowerment Group of faculty and students, as well as a 1992 essay by Moncrieff Cochran, "Parent Empowerment: Developing a Conceptual Framework." Empowerment is defined as "an intentional, dynamic, ongoing process centered in the local community, involving mutual respect, critical reflection, caring, and group participation, through which people lacking an equal share of valued resources gain greater access to and control over those resources." Contributors to the bulletins collected here include Maria Chavez, Heather Weiss, Josephine Allen, Donald Barr, Joyce Hoelting, Mary Kay Stranik, and Barbara Clinton, among others.

Videotapes

Telling Your Family Story . . . Parents as Presenters (with video guide). Produced by Stacy King, Parent Projects, Wisconsin Personnel Development Project, Waisman Center, University of Wisconsin-Madison. Available from Child Development Media, Inc., 5632 Van Nuys Blvd., Suite 286, Van Nuys, CA 91401. Tel. 800-405-8942. 30 min., $60.

This videotape and guide are designed to help family members and caregivers of children with special needs enhance their presentation skills as they tell their family stories in a variety of settings—informal parent support groups, professionals' offices, classrooms, and conferences. Family stories can also be used in testimony before legislators and administrators and in public education, to increase understanding of the concerns of families of children with special needs. The video and guide discuss the overall process and specific techniques of preparing for a presentation. Three individuals telling their family stories illustrate the guidelines.

Protective Urges: Working with the Feelings of Parents and Caregivers (with video magazine) (1996). Produced by WestEd (formerly Far West Laboratory), Center for Child and Family Studies in collaboration with the California

Department of Education, Child Development Division. Executive Producer, J. Ronald Lally. Available from California Department of Education, Bureau of Publications Sales Unit, P.O. Box 271, Sacramento, CA 95812-0271. Tel. 916-445-1260 or 800-995-4099 (credit card orders). 27 min. $65.

The desire to shield an infant from harm—the protective urge—seems to be a fundamental drive, common to parents and to others caring for infants. When an infant is in child care, strong protective feelings in parents and caregivers can lead to a rich partnership, but protective urges can also cause both parent and caregiver to question each other's care. In this video, parents of infants in child care speak candidly about their fears and concerns, and a group of infant/toddler caregivers talk with psychologist Alicia Lieberman about the feelings they have experienced in working with parents. The video presents a four-step process designed to help caregivers better understand their own emotional reactions and the reactions of parents; demonstrate competency, honesty, and understanding as a base for family support; and work together with parents to protect and nurture the infant.

Developmental Milestones

The **Freddie Mac Foundation** has awarded ZERO TO THREE a three-year grant totaling $528,477 to help leaders of Metropolitan Washington, D.C.'s infant/family programs improve the quality and comprehensiveness of their child development and family support services. A March, 1997 conference, open to all programs in the area, will emphasize the cornerstones of program design underlying Early Head Start—child development, family development, staff development, and community building. An advisory group will help ZERO TO THREE and Freddie Mac select up to ten area programs to receive more intensive technical assistance. Working with programs over three years, this effort will enable ZERO TO THREE to begin the establishment of a regional Learning and Development Network, dedicated to improving the quality and comprehensiveness of services for families with infants and young children. **Potential candidates for the position of Project Director may request a position description and list of qualifications by contacting Emily Fenichel at ZERO TO THREE via fax (202/638-0851) or e-mail (ZEROTOTHREE@aol.com).**

The **Katharine Pollard Maddux Memorial Mental Health Foundation** of McLean, Virginia has awarded a grant to ZERO TO THREE to support the continued work of Margaret Jones as developmental specialist with Sleepy Hollow Pediatric Associates in Falls Church, Virginia, as part of ZERO TO THREE's Developmental Specialist in Pediatric Practice project. This grant was made possible by a bequest from Mrs. Paul Landon Banfield to the Maddux Foundation. Mrs. Banfield was a founding member of the Maddux Foundation and served on its Board of Directors until her death. Since its establishment in 1972, the Maddux Foundation's mission has been to give infants and young children the earliest intervention and best possible remediation in order to improve their lives, through professional help for children and support for their families.

Friends and colleagues of **Martha Leonard, M.D.** celebrated her 80th birthday by making contributions to ZERO TO THREE in her honor. A supporter of ZERO TO THREE since its founding, Dr. Leonard, a 1940 graduate of Johns Hopkins Medical School, began advocating for very young children as a pediatrician in private practice in New Brunswick, New Jersey when she urged local hospitals (unsuccessfully at that time) to permit "rooming-in" for mothers and their newborns. After volunteering at the Hospital Albert Schweitzer in Haiti, Dr. Leonard went to the Yale Child Study Center, first as a fellow and then as a full-time member of the faculty of the Center and the Department of Pediatrics. Her service, teaching, and research activities from 1962-1986 included evaluation of young children with developmental problems, support for first-time mothers considered at social and emotional risk, and study of failure to thrive. Advocacy efforts have included chairmanship of a Connecticut multidisciplinary committee on child abuse that prepared comprehensive legislation, fought successfully for its passage, and saw the law become a model for other states. Dr. Leonard has served for many years as chair of the Government Liaison Committee of the Connecticut Chapter of the American Academy of Pediatrics, recently honored by the Connecticut Association for Human Services for its advocacy for children. As part of this award, Dr. Leonard was named one of several "Mothers of the Year."

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This index groups by topic the articles and reviews of publications and videos that have appeared in *Zero to Three* from August/September, 1995 through June/July, 1996. When an item is listed as "review of," this means that a brief summary of the publication or video appears in the issue of *Zero to Three* indicated. The special themes for each issue of Volume 16 have been as follows:

August/September, 1995
Expanding the boundaries of primary pediatric care

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